S. Hrg. 101-832

FISCAL YEAR 1991 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

FISCAL YEAR 1991 BUDGET FOR VETERANS' PROGRAMS AND LEGISLATION REGARDING ADMINISTRATIVE REORGANIZATIONS (S. 2101 AND S. 2103)

FEBRUARY 23, 1990

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
31-737 ⇆ WASHINGTON : 1990

S761-14

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON VETERANS' AFFAIRS

ALAN CRANSTON, California, *Chairman*

SPARK M. MATSUNAGA, Hawaii
DENNIS DECONCINI, Arizona
GEORGE J. MITCHELL, Maine
JOHN D. ROCKEFELLER IV, West Virginia
BOB GRAHAM, Florida

FRANK H. MURKOWSKI, Alaska
ALAN K. SIMPSON, Wyoming
STROM THURMOND, South Carolina
ARLEN SPECTER, Pennsylvania
JAMES M. JEFFORDS, Vermont

JONATHAN R. STEINBERG, *Chief Counsel/Staff Director*
ALAN C. PTAK, *Minority Chief Counsel/Staff Director*

CONTENTS

FEBRUARY 23, 1990

Page

Fiscal Year 1991 Budget for Veterans' Programs and Legislation Regarding Administrative Reorganizations (S. 2101 and S. 2103) 1

STATEMENTS BY COMMITTEE MEMBERS

Chairman Cranston 1
  Prepared statement of Chairman Cranston 129
Senator Graham 71
  Prepared statement of Senator Graham 150
Senator Matsunaga 149
Senator Mitchell 148
Senator Murkowski 138
Senator Rockefeller 45
Senator Thurmond 25

WITNESSES

Bollinger, John C., Associate Legislative Director, Paralyzed Veterans of America, accompanied by Dr. Donald L. Custis, Senior Medical Advisor to the Independent Budget 61, 98
  Prepared statement of Mr. Bollinger 181
Brown, Jesse, Executive Director, Disabled American Veterans 60, 100
  Prepared statement of Mr. Brown 165
Collins, Hon. Thomas E., III, Assistant Secretary for Veterans' Employment and Training, Department of Labor, accompanied by Richard Larson, Executive Assistant, Veterans' Employment and Training Service 48
  Prepared statement of Mr. Collins 157
Derwinski, Hon. Edward J., Secretary, Department of Veterans Affairs, accompanied by Hon. Anthony J. Principi, Deputy Secretary; Dr. John Gronvall, Chief Medical Director; Ray Avent, Acting Chief Benefits Director; Jo Ann K. Webb, Director, National Cemetery System; Raoul L. Carroll, General Counsel; and Mark Catlett, Deputy Assistant Secretary for Budget 4
  Prepared statement of Secretary Derwinski 151
Fisher, Dr. Elliott, Assistant Professor, Department of Community and Family Medicine, Dartmouth Medical School, on behalf of the American Federation for Clinical Research 113
  Prepared statement of the American Federation for Clinical Research 214
Gallagher, Barbara L., Director, VA Medical Center, Baltimore, MD 63
Geyer, Dr. Stanley J., Chief of Staff, VA Medical Center, Seattle, WA 63
Gresham, Henry W., Director, VA Regional Office, Manchester, NH 76
Horvath, Dr. Thomas B., Chief of Staff, VA Medical Center, Brooklyn, NY, on behalf of the American Psychiatric Association 111
  Prepared statement of the American Psychiatric Association 210
Jones, Robert L., Chairman, Committee on the Independent Budget and National Executive Director, AMVETS 57, 101
  Prepared statement of Mr. Jones 161
Lemons, Stephen L., Director, VA Regional Office, Waco, TX 76
Maye, James, Director, VA Regional Office, Los Angeles, CA 76
McReynolds, Jack, Director, VA Regional Office, Denver, CO 76
Moore, Joseph L., Director, VA Medical Center, Chicago (Lakeside), IL 63

Page
Nebeker, Hon. Frank Q., Chief Judge, U.S. Court of Veterans Appeals, accompanied by Melanie G. Dorsey, Executive Officer and Clerk of the Court 54
    Prepared statement of Judge Nebeker 160
Pannell, Roy E., National Vice President, American Federation of Government Employees, AFL-CIO 115
    Prepared statement of Mr. Pannell 216
Randall, Malcom, Director, VA Medical Center, Gainesville, FL 63
Rivers, Larry W., Executive Director, Veterans of Foreign Wars of the United States 58
    Prepared statement of Mr. Rivers 163
Sherwood, Thomas A., Director of Health Policy and Planning, Vietnam Veterans of America 123
    Prepared statement of Mr. Sherwood 234
Smith, Ralph E., Director, VA Regional Office, Roanoke, VA 76
Waldman, Dr. Robert H., Dean, University of Nebraska College of Medicine, on behalf of the Association of American Medical Colleges 109
    Prepared statement of the Association of American Medical Colleges 206
Walsh, Samuel J., Deputy Director, National Legislative Commission, The American Legion 122
    Prepared statement of Mr. Walsh 221

APPENDIX

Bills:
    S. 2101—A bill to waive the waiting period requirement of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization involving the Loan Guaranty Division at the Togus Veterans' Affairs Medical and Regional Office Center 127
    S. 2103—A bill to waive the reporting and waiting period requirements of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration 128
DAV white paper on the compensation and pension pending backlog 296
Statements:
    American Association of Dental Schools 240
    Association of Professors of Medicine 246
    Bennett, Hon. Charles E., U.S. Congressman from the State of Florida 248
    California Association of Realtors 248
    Daschle, Hon. Thomas A., U.S. Senator from the State of South Dakota 252
    Fascell, Hon. Dante B., U.S. Congressman from the State of Florida 254
    Friends of VA Medical Care and Health Research 255
    Goss, Hon. Porter J., U.S. Congressman from the State of Florida 269
    Hutto, Hon. Earl, U.S. Congressman from the State of Florida 269
    Lewis, Hon. Tom, U.S. Congressman from the State of Florida 270
    Mack, Hon. Connie, U.S. Senator from the State of Florida 270
    Manufactured Housing Institute 271
    Mortgage Bankers Association of America 277
    National Association of Home Builders 281
    National Association of Realtors 285
    Nelson, Hon. Bill, U.S. Congressman from the State of Florida 287
    Non Commissioned Officers Association of the United States of America 288
    Nurses Organization of Vetrans Affairs 293
    Smith, Hon. Lawrence J., U.S. Congressman from the State of Florida 294
Written questions and the responses:
    Chairman Cranston to:
        Court of Veterans Appeals 306
        Department of Labor 319
        Department of Veterans Affairs 343
        Fisher, Dr. Elliott 455
        Independent Budget organizations (AMVETS, DAV, PVA, and VFW). 457
        Waldman, Dr. Robert H. 474
    Senator Cohen to the Department of Veterans Affairs 476
    Senator Mitchell to the Department of Veterans Affairs 481
    Senator Rockefeller to the Department of Labor 488

FISCAL YEAR 1991 BUDGET FOR VETERANS' PROGRAMS AND LEGISLATION REGARDING ADMINISTRATIVE REORGANIZATIONS (S. 2101 AND S. 2103)

FRIDAY, FEBRUARY 23, 1990

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 8:08 a.m., in room SH-216, Hart Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, Rockefeller, Graham, and Thurmond.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. Good morning to you all. Welcome to today's hearing on the fiscal year 1991 budget for veterans' programs and on two administration-proposed reorganizations.

Our agenda is very full this morning. Today's witnesses include panels from the Departments of Veterans Affairs and Labor, the U.S. Court of Veterans Appeals, veterans' service organizations, VA field officials from several medical centers and regional offices, and organizations involved with VA health care and research.

Before getting to the many issues involved in today's hearing, I would like to thank the many VA officials who worked so hard in preparing the agency's testimony and answers to my many prehearing questions and the informal inquiries made by committee staff members. A special note of thanks to Marie Pringle in VA's budget office for coordinating these answers.

Unfortunately, I must also note my disappointment with the delays caused by OMB in reviewing these answers. Almost all of the questions concerned factual information. I do not believe OMB was justified in holding up VA's responses. Although we received some answers yesterday evening, most of the formal questions are still unanswered.

I want to thank the many other witnesses who cooperated with us in providing their testimony in a timely fashion as requested. Your efforts are very much appreciated.

Copies of my detailed statement are available at the press table so I will just briefly address some of the major aspects of the issues before us today.

The $12.24 billion request for the medical care account for the coming fiscal year is an 8.1-percent increase of nearly $913 million over the funding level available for the current fiscal year.

My hat is off to Secretary Ed Derwinski for bringing about the best VA medical care request submitted by a President in over a decade, and we are very grateful to you for that. It is a major breakthrough in the battle to overcome the large budget shortfalls VA has been saddled with since at least the summer of 1988.

This request contains a number of very positive features. It would allow for the restoration of over 2,300 full-time positions, including nearly 800 more nursing positions. It also includes very welcome proposals for full funding of an anticipated 3.5-percent January 1991 pay raise, $70 million for pay boosts for VA doctors and nurses, and $8.3 million for improved health-care quality assurance programs.

However, even with the significant increase in funding proposed by the President in the medical care account, some important needs are not dealt with adequately—especially PTSD and other mental-health treatments. I would also like to see more emphasis on the needs of homeless veterans, veterans needing readjustment counseling, and veterans needing extended care in geriatric programs and innovative ambulatory care approaches to avoid institutionalization.

In contrast to the generally positive medical care budget, the proposed 7-percent, $14.1-million cut in medical and prosthetic research is shortsighted and a big disappointment. Not only does VA research make a major contribution to our national effort to combat disease and disability, but it is vital to maintaining the high quality of health care for the individual veteran patient by attracting highly qualified health and mental health professionals to VA.

I also have reservations about the proposal for a large-scale effort to beef up collections from health insurers by assigning 800 employees, including 300 new ones, to these duties, and by charging insurers for the non-service-connected care of seriously disabled service-connected veterans.

I would prefer that VA contract out as much of the collection activity as possible and keep its own work force focused on patient care. I feel strongly that the generally beneficial medical care request for fiscal year 1991 makes it very obvious that there is a critical need right now—right now—for supplemental funding for the current fiscal year.

I have been joined by more than 50 other Senators in a pending letter to President Bush urging that he extend his commitment to VA health care by submitting a fiscal year 1990, $252-million supplemental funding request to restore the shortfall resulting from sequestration and a VA miscalculation in personnel costs that was not anticipated when he signed the fiscal year 1990 VA appropriation into law on November 9.

I believe that the current funding level will mean that tens of thousands of veterans this year will be denied care entirely or the quality of care we owe them. The VA health-care system cannot furnish that high quality of care unless it is provided with consistent, as well as adequate, funding levels. Stop-and-start funding means bad care.

I am encouraged by the commitment to the VA health-care system manifested in the President's fiscal year 1991 medical care request, and therefore will continue to urge him as earnestly as I possibly can to fulfill that commitment now—not 7 months from now—by submitting a 1990 supplemental request to provide funding this fiscal year for the level of services that the budget request contemplates for fiscal year 1991.

I also want to compliment the Secretary on a strong improvement in the construction budget request. It represents a major upturn.

I also want to thank him once again for his excellent work in getting two major and very urgent California hospital projects included, as well as providing for the establishment of the Bakersfield Outpatient Clinic and other California needs.

With respect to disability compensation, on February 7, I introduced S. 2100, a bipartisan measure cosponsored by the ranking minority member and virtually the entire committee, to provide a COLA for compensation and TIC rates equal to that provided for Social Security and VA pension recipients. I also will propose adding $36 million for interim Agent Orange-related benefits that VA would pay under S. 1153, the Agent Orange Compensation bill, that I joined with Senators Daschle and Kerry in introducing during the last session and which the Senate overwhelmingly passed on August 3, 1989, and again on October 4, 1989, in S. 13.

I will propose, as well, a similar addition to accommodate the cost of legislation I am preparing that would add certain presumptively service-connected diseases and make other changes to benefit radiation-exposed veterans.

Perhaps the most objectionable features of the President's fiscal year 1991 budget for VA are the proposals for major changes in the VA home loan program, including the proposals to increase the fee, impose a downpayment requirement, and skew the no-bid formula in such a way as to reduce dramatically the attractiveness of the VA loan guaranty program to lenders.

I also would like to point out that the recent and current health-care funding shortfalls have highlighted VA's failure to ensure the timely distribution of prosthetic appliances and services for veterans whose service to their country included the sacrifice of a limb or the loss or impairment of the ability to walk or see or hear. This is totally unacceptable, and I will keep working to see that it does not continue.

Before moving to the non-VA programs, I want to mention certain other major aspects of the President's budget which I will be covering in detail in my questions this morning. These include: the proposed 266 FTE decrease in VBA staffing, despite the need for more, not fewer, staff to meet veterans' needs; and the need for additional support for the National Cemetery System.

Finally this morning we will focus on two non-VA budgets: the Department of Labor's Veterans' Employment and Training Service, and the new U.S. Court of Veterans Appeals. While there are extremely disappointing inadequacies in the funding proposed for Veterans' Employment and Training Services, the budget for the

U.S. Court of Veterans Appeals was, as a result of our enabling legislation, not subject to OMB review and therefore appears to be satisfactory.

Again, thank you all for your efforts in preparing for today's hearing. I look forward to your testimony.

[The prepared statement of Chairman Cranston appears on p. 129.]

Chairman CRANSTON. Now I'd like to welcome Secretary Derwinski, Tony Principi, and the other witnesses for the VA. I welcome each of you. I look forward to your testimony with great interest and to continuing to work closely with you and your fine staff to protect and support the interests of our Nation's veterans.

If you would now proceed in any way you see fit with your statement, but please do try to summarize it in about 5 minutes.

Your prepared statement, of course, will appear in its entirety in the record immediately following your oral statement.

Ed, if you would like to take a minute to introduce those with you from the VA it won't count against your 5 minutes.

I have a large number of questions to ask and our time is limited. I, therefore, would greatly appreciate it if you and all the other VA witnesses would keep your answers as concise as possible. Please proceed.

Again, we welcome you. And, again, I thank you for your many very fine accomplishments.

STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY HON. ANTHONY J. PRINCIPI, DEPUTY SECRETARY; DR. JOHN GRONVALL, CHIEF MEDICAL DIRECTOR; RAY AVENT, ACTING CHIEF BENEFITS DIRECTOR; JO ANN K. WEBB, DIRECTOR, NATIONAL CEMETERY SYSTEM; RAOUL L. CARROLL, GENERAL COUNSEL; AND MARK CATLETT, DEPUTY ASSISTANT SECRETARY FOR BUDGET

Secretary DERWINSKI. Thank you, Senator.

I was hoping when you started your statement and made reference to our record budget that you'd stop right there. I felt that was the high-water mark of the hearing and we will slowly slide downhill from now on.

Actually, in a more optimistic vein, I assure you we will cooperate with your time constraints. As I was trained in the House, I understand the art of terse commentary.

I would like to introduce, on my left, Mr. Mark Catlett, who is our Deputy Assistant Secretary for Budget; Raoul Carroll, our General Counsel; Jo Ann Webb, Director of the National Cemetery System; on my right, Mr. Ray Avent, who is the Acting Director of Veterans Benefits; and, of course, a man who needs no introduction to you, Dr. John Gronvall.

I would ask that my entire statement be placed in the record, and I will be brief, as you indicated.

Chairman CRANSTON. It will be placed in the record immediately following your oral presentation.

Secretary DERWINSKI. Actually, you took a good deal of our material and used it properly—especially your emphasis on the 1991 budget figure, which we think represents a significant step forward in understanding of the long-term needs of the VA. We think it heralds a new era of ever more practical budget relationships with the OMB.

We will emphasize, as you also indicated, the areas where veterans do need help, which include our role in the drug treatment effort. We are cooperating with Mr. Bennett and his overall efforts, but our focus is where we have our expertise, which is in the area of drug treatment. We believe, in the long run, one of the ways we will whip the drug scourge is by effective treatment of those people—in our case, veterans—who suffer from addiction.

We have a very positive and ongoing effort to increase our sharing and contractual agreements with the DOD in such a way which I believe will be mutually beneficial. And at a time when the DOD faces obvious budget constraints we think they will be driven in a proper fashion to more sharing agreements with us. We believe it will work well for the current servicemen and for our veterans.

We are, with the leadership of Dr. Gronvall, emphasizing patient environment. I'd like to point out that we have been in the forefront of efforts to make the VA a smoke-free entity, wherever possible. We have had some basic success. We still have some work to do, but we think it is consistent with our leadership role in medicine.

You had mentioned, sir, the question of the homeless. We have been working very hard in interagency meetings to do our share in the expansion of efforts to cure the problem of so many homeless, and, in our case, homeless veterans. We have a special outreach program we think is successful, although much more has to be done.

Last but not least is the aging question. Here, again, we are faced with the basic facts of life: veterans of all wars are growing older and we must take the lead in serving those veterans. The need to expand the services in geriatric medicine is obvious, and that must include, then, an adjustment of our facilities. Older veterans need inpatient care, but more than that they also need the best outpatient and extended care settings that we can provide.

As you know, Senator, we have asked for support for a Realignment Commission. Since it doesn't look as if it is possible to have that worked out quickly enough by legislative sanction, we are going to move ahead administratively to set up a commission which we will call the Commission on the Future Structure of VA Health Care. It will be staffed primarily by independent medical experts to tell us where the VA should be in the next 5, 10, 15, 20, and 30 years.

We have made a commitment that it will not involve the closing of any of our medical centers. The emphasis will be on improving the quality of medical care across the country for all veterans, with a special emphasis on the legitimate projections we can make regarding where our veterans will be located and their needs—especially the aging factor that you, yourself, have cited.

While we appreciate your position, we do want you to know that we are supportive of the proposals that we have submitted for the nominal downpayment on loans. I'd like to point out that years and years ago, before I entered public life, I ran a small savings institution, and I can tell you that there is nothing that makes a homeowner more responsive than having a basic investment. The downpayment is the basic guarantee for effective repayment. I think it is a philosophical but practical point.

Our proposal is merely that there be a downpayment of 4 percent on loans over $25,000. My deputy, Tony Principi, has worked hard to see if we can convince the Congress of the practical nature of our proposal.

On that point, Mr. Chairman, may I point out that we do have a special challenge in our benefits area. We would hope that, notwithstanding the complicated schedule that is automatic in the Senate, that the confirmation of D'Wayne Gray as our Chief Benefits Director could be expedited. I understand that the hearings before your committee went well, and I'm not aware of any opposition. I would hope that subject only to, even at this early stage, hectic Senate schedules, that the confirmation might be favorably looked upon.

And last but not least I want to thank you, Senator, for introducing S. 2101 and S. 2103, which are our management reforms. We appreciate your thoughtfulness and your leadership in that area.

Again, last but not least for the second time, we'd like to emphasize that we think we have achieved a practical relationship with OMB. We have worked hard to convince them that we have been improving the system. We are making slow, steady steps toward what we believe is better management and, as a result, we think that, while we will never have a perfect world and have every dollar we will ask for, we think OMB in fiscal year 1991 and the years ahead will be much more practical in responding to our proposals.

If I may make one personal note, I'd also like to advise you and your committee members and staff that we have a special alignment in our front office structure. Mr. Principi and I share the same staff. One of the reasons is that there have been times in the past and in other departments and agencies of Government where the Secretary and Deputy have been different armed camps. In our case we work together especially well. We have a totally coordinated front office. The practicality of it is that no one could end-run the system and bypass the Deputy in his areas of jurisdiction and come to me to have me override him, or vice versa. It is a system that is working well.

We tried to bring harmony and coordination to the front office, and therefore to the entire VA. We have been stressing teamwork, and hopefully it will manifest itself in more effective services that we can render our veterans.

Thank you. We are now open to any questions you have.

[The prepared statement of Secretary Derwinski appears on p. 151.]

Chairman CRANSTON. Thank you very much, Ed. I appreciate that fine and succinct statement.

That arrangement you described with Tony Principi indicates your high regard for him, and we share that high regard. That's interesting, and I'm sure it will be an effective arrangement.

I do, as you know, have a great many questions, so I will get right to them.

Your answer to prehearing question 6 regarding the impact of sequestration this year suggests that the reductions might not have an impact on medical care and services this year. However, wouldn't you agree that shifting resources from equipment maintenance, repair, and replacement accounts to meet the shortfall in funding for the immediate costs of direct services will probably have an adverse impact on the availability of care and benefits in future years?

Secretary **Derwinski**. I'll share that response, if I may, with Dr. Gronvall. But let me just run through the basic figures for you.

If you will recall, our 1989 original request—that is, the administration's 1989 original request—was $10.3 billion. The actual figure that we received in fiscal year 1989 after the supplemental which I had requested in one of my first acts as Secretary was approximately $10.9 billion. Our original 1990 request was $10.741 billion; the actual funding after congressional action and sequestration was $11.3 billion, which left us with almost $500 million above the original request. Actually, I had earlier requested $512 million additional for fiscal year 1990, and our figure basically came out very close to that request.

So, in 1990, while we did have our figures affected by sequestration, we came out far above the original request, very close to what we had asked for totally separate from the budget process.

Then we come to fiscal year 1991, which is the best figures we have had in advance in years. It gives our people a chance to plan, to look ahead to 1991 as a better year. There is no uncertainty, as there often has been in the past. They don't have to wait for any supplemental. They've got a very good budget figure up front.

I should also add that we're right at the end of the 5th month of this fiscal year, and if there were a supplemental under consideration and it runs through the same course as the 1989 supplemental—that took 4 months of nail biting—if you recall, when we finally received the funds it left us well into the fourth quarter of the fiscal year before we were able to benefit from the supplemental.

So looking at it from our perspective, a very good 1991 figure gives us administrative flexibility to adjust in fiscal year 1990.

I'd like to yield to Dr. Gronvall at this point because I believe he is better equipped to give you more of the details.

Dr. **Gronvall**. Let me really focus only on a specific part of your question, because I think the Secretary laid out the total framework of 1989——

Chairman **Cranston**. If you could focus on the effect in 1991, not this year.

Dr. **Gronvall**. Yes. Well, in 1990 when there was the sequestration and the conference reduction to fund the drug program, and then our recalculation on the salary program, we, in fact, adjusted downward our projections for the number of patients we would treat in the hospitals and the number of outpatients. That adjusted figure projects forward into 1991, however, the requested increase in 1991 will provide additional staff, and we have projected increases in patient care above the adjusted 1990 base.

Chairman **Cranston**. Is sufficient funding in MAMOE proposed for fiscal year 1991 to rebuild Central Office staff and is that a management goal?

Dr. **Gronvall**. The funding request for MAMOE for 1991 would essentially preserve what we think is the absolute minimum, but necessary minimum, of staffing. As you are well aware, of course, we are having a very difficult time this year because of a major reduction, but we believe we can operate our system if we receive the funding in MAMOE requested in 1991.

Chairman **Cranston**. So you would be rebuilding from a bad 1990 situation?

Dr. **Gronvall**. Correct.

Chairman **Cranston**. Ed, I appreciate your efforts to find a more rational method for the preparation and collection of health insurer billings. However, I am inclined to seek a greater role for a contract operation which could make it possible for many of the 500 VA employees now engaged in collection efforts to return to jobs related to furnishing health-care services to veterans.

I'd like to work together with you and with Senators Murkowski and Graham on this, and I have written questions to submit to you with respect to the contract approach.

Going on to something else, in order to bill a third-party payer under the VA-proposed collection plan, VA must ascertain whether care to a service-connected veteran is for a service-connected or a non-service-connected condition.

Although VA states that medical administration personnel can make that determination, you have not yet demonstrated how an interested insurance company could have sufficient access to the patients' medical care and disability rating records to satisfy its own verification needs. Blue Cross/Blue Shield raised this issue, among others, in opposing the administration's proposal.

What process might be developed that would meet the needs of the insurance companies, while maintaining standards of patient confidentiality and a reasonable VA administrative workload?

Dr. **Gronvall**. If I may, Mr. Chairman, you are quite right that the details of how we would do that to the satisfaction of the insurance carriers have not been worked out. We don't view that question, however, as one that is unique. By that I mean, each time we have changed or instituted a new third-party recovery system, we have had to work in very elaborate detail with the insurance carriers to ensure that our records support the bills that we submit and that they have a way to review them.

They are tough questions and detailed questions, but we have staff with the capability, I believe, of accomplishing that, working basically in collaboration with the insurance industry if the collections are authorized by law. We have succeeded in the past in doing that.

Chairman **Cranston**. Do you think it would be advisable to convene a meeting with the insurance carriers to explore this?

Dr. **Gronvall**. The way that we have worked out billing arrangements in the past, once they are authorized by law, is to work very carefully with the insurance carriers through the Health Insurance Association and individual carriers. So the answer is yes.

Chairman **Cranston**. Well, the service-connection business didn't come up before, so I suggest you meet with the insurance carriers and explore that, because the committee is going to have a hard time dealing with it until we know how it is going to be handled.

Dr. GRONVALL. That is why I said this was a new dimension, but not unique in the sense that all billing to third parties has to document the care to the satisfaction of the insurer.

Chairman CRANSTON. Ed, I'd like to say that I think it is necessary, so we understand what we are authorizing, for a session to be held with the insurance carriers to see how you work out this problem. If you could do that, I'd appreciate it.

Secretary DERWINSKI. That's an entirely practical suggestion. We appreciate it.

Dr. GRONVALL. We would be pleased to do that.

Chairman CRANSTON. And let us know how that works out.

A recent audit by the VA Inspector General recommended that responsibility for third-party collections be assigned to one place, in the Central Office. It recommends the Chief Medical Director. Another possibility would be under the Assistant Secretary for Finance.

Have you considered each of these options, and have you reached a decision? If so, what is your decision?

Mr. Principi. We still have both options under consideration, and we intend to implement one in the very near future.

Chairman CRANSTON. Let us know when you do work it out.

Mr. PRINCIPI. Yes, sir.

Chairman CRANSTON. Ed, in a January 18, 1990, letter I urged you to provide $200,000 for the Medical Followup Agency. Your January 31 response said you had asked for a report on the subject and would be back in touch as soon as possible with an answer. Do you know when that report will be completed?

Secretary DERWINSKI. Mr. Chairman, we are deliberating intensively on that question. I have talked, in fact, this very week to the president of the Institute of Medicine, the organization in which the Medical Followup Agency resides. I believe that within the next 2 weeks we will come to a conclusion on whether we will be able to provide the funding requested.

Chairman CRANSTON. Ed, I have a lot of respect for John in all areas, but this has been going on for a year. If you could try to expedite that, it would be helpful.

Secretary DERWINSKI. I will sit down and work at it immediately.

Chairman CRANSTON. Have VA officials spoken with officials at the Department of Defense and NIH regarding sharing the estimated $500,000 annual core funding cost or the estimated $100,000 to hire a physician/epidemiologist to be the new director of MFUA?

Dr. GRONVALL. Mr. Chairman, we have had direct discussions with officials both at NIH and at DOD and at the Institute of Medicine, the parent organization.

Chairman CRANSTON. Ed, if you can respond to that as soon as you can, I'd appreciate it.

Dr. Gronvall, I understand that the VHS&RA western region has, or will be shortly recommending, an additional $231,000 this fiscal year for staff and equipment at the new VA health-care facility in Redding, CA. That facility is heavily oversubscribed now. Do you know when we can have a response from the Resource Allocation Committee to that important request?

Dr. **Gronvall**. I don't have that answer at my fingertips, but I know it is one of the questions that we have been working on, and we will have a written response to you shortly.

Chairman **Cranston**. Thank you. Do you think probably in the next 2 weeks?

Dr. **Gronvall**. Yes.

Chairman **Cranston**. Good.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

There are some short-term staffing and space needs which have been identified by VAMC Martinez as a first phase in the enhancement of services at the Redding Medical Office/Clinic. A request for resources for consideration by the VHS&RA Resource Allocation Committee was prepared which identified the following immediate requirements:

FTEE: 5
Person Services Dollars: $182,018
Travel: $9,000
TOTAL: $261,018

This request to the RAC was remanded to the Director, Western Region to provide within existing Regional resources. The Director, Western Region is committed to providing these additional resources at the earliest possible date.

Chairman **Cranston**. Regarding facility activations, what has the overall percentage of actual slippage been for fiscal year 1985 through 1989? I'd like to also ask how these compare with OMB estimates of slippage and the 25 percent figure used to reduce your 1991 activations request?

Dr. **Gronvall**. I believe the best way would be for us to submit that in detail for each year to give each of those comparative figures. We will certainly do that.

Chairman **Cranston**. Fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Slippage Rates for the years 1985 through 1989 are as follows:

1985	1986	1987	1988	1989
25%	25%	17%	24%	18%

The projected slippage rates for FY 1990 and 1991 (25 percent) are consistent with prior experience. We expect the recent trend toward lower slippage rates due to construction delays to continue into the 1990's. Starting with the 1990 budget, distributions of project activations were made using a programmed formula based on estimated completion dates and project construction status. With certain exceptions projects are not budgeted for activations in the current year unless they are under construction.

Chairman **Cranston**. Dr. Gronvall, what is the future of RAM, the Resource Allocation Methodology?

Dr. **Gronvall**. It is under active development for a revision. The previous model had served us well when it was adopted. It became apparent that it was forcing an overly-extensive attention on expanding quantity of care and when, because of fiscal constraints, we had to cut back on quantity to preserve quality, we initiated active planning to revise the model.

We have proposals for specific revisions that are now being actively deliberated, and I think during this year a revised approach will be adopted that will be better suited to funding the kind of care that needs priority.

Chairman **Cranston**. When will the RAM go back into effect?

Dr. GRONVALL. We will, I believe, during this current fiscal year adopt a revision that will actually be the basis for the allocation of the 1991 request.

Chairman CRANSTON. What are your plans to implement changes in the indications and dosages recommended for the use of AZT for persons who are HIV positive at varying levels of symptomology in light of the recent announcements from HHS regarding lower effective doses of treatment of asymptomatic HIV-positive persons with intermediate-level T-4 cell counts?

Dr. GRONVALL. We were very encouraged to find the good news both that the drug is effective and, in fact, may be effective at lower levels. Our AIDS Office is reviewing all of that literature, and working with our best clinicians in the field. We are in the process of adopting a different basic approach using a lower dose and adjusting the drug dosage for veterans with AIDS symptoms but not full-blown AIDS.

We are also conducting in the VA a clinical trial on the use of AZT for AIDS-related complex. We will have our own data within the next year that will contribute to improving the decisionmaking that our doctors will carry out as to what dosage can be provided at what level. It is a complicated question, and I think we ought to follow up with a summary of where we stand on the dosage levels at each stage of the disease.

Chairman CRANSTON. That would be helpful. How far away are you from actually proceeding?

Dr. GRONVALL. We are very close. I can't tell you exactly, but that is a very active deliberation that I believe will be brought to conclusion within the next month or two.

Chairman CRANSTON. Good.

John, I want to focus for a moment on the current condition of the health-care system and how it compares to the situation that prevailed a year ago at this time.

Generally, would you say that your fiscal situation is about the same or better or worse now than a year ago?

[Subsequently, the Department of Veterans Affairs furnished the following information:]

A technical advisory group on therapeutics was established in February, 1990 and met by teleconference on February 22. The expanded use of AZT in patients with CD4 counts of 200–500 and low dosage regimens were discussed at that time. The group advised the AIDS Program Office staff that any decision on a VA wide policy on expanded AZT use and dosage should await the recommendations of a conference on the state of the art on AZT therapy for early HIV infection scheduled for March 3, 1990. Two members of the technical advisory group had been asked by the National Institute of Allergy and Infectious Diseases to participate in writing the report of the conference. Another member, who presented the preliminary findings of the VA cooperative clinical trial on the use of AZT for AIDS related complex (ARC), and an AIDS Program Office staff member were also present for the public portion of the conference. Concerns were expressed about the development of resistant strains of HIV with expanded use and the comparability of the groups being studied given the short time frame of the studies. The report of the conference has not yet been released. In the meantime, VA physicians are expected to use their best clinical judgment in prescribing AZT and are advised to carefully monitor CD4 cell counts. To assist them, three teleconferences for physicians were held in January and February entitled "AIDS/HIV: Current Diagnosis and Treatment" during which three experts, two of whom are also on the therapeutics advisory group, discussed the issues.

Dr. Gronvall. When you say "fiscal situation," I would say that the sense of capacity supported by the budget in the hospital system now is approximately at the same level we were a year ago. I think it is quite different now, though, because we are looking ahead to a better request with solid support throughout the entire coming year so that our situation is remarkably different than a year ago where we were in a decline, got slightly bailed out at the end of the year by a late supplemental, and we were suffering from the up and down effect of uneven funding.

Chairman Cranston. So that has, I presume, a considerable impact on morale in the agency?

Dr. Gronvall. Yes. The prior pattern of starting the year low and having to cut back and then hoping for a supplemental, which comes late, and we try to build up late in the year only to cut back the following year is very negative to morale. So, in that sense, the situation right now is significantly better than a year ago.

Chairman Cranston. Digging into the detailed aspects of this beyond the fiscal situation generally, please describe the current situation in each of the following areas and how it compares with that of a year ago. First, the number of patients being furnished hospital care.

Dr. Gronvall. Our belief is that we will, throughout fiscal year 1990, be able to treat in-hospital slightly more veterans than we did in all of fiscal year 1989. I have the numbers which I could give, but they are detailed.

Chairman Cranston. Could you supplement that for the record?

Dr. Gronvall. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Patients treated	1989 actual	1990 current estimate	Increase/ decrease
VA hospitals	1,027,581	1,032,569	+4,988
VA nursing homes	26,561	26,617	+56
VA domiciliaries	17,822	19,150	+1,328
Non-VA	79,884	82,860	+2,976
Total patients treated	1,151,848	1,161,196	+9,348
Total outpatient visits (000's)	22,643	22,859	+216

Chairman Cranston. What about the number of patients being furnished, and the duration of, nursing home care?

Dr. Gronvall. Our nursing home care program this year will be at a lower level than it was in 1988, but slightly above the level that it was in 1989 by some 2,000 patients.

Chairman Cranston. That's basically a flat situation then, I guess, all things considered.

Dr. Gronvall. That's on a base of 75,000 patients treated, so that's a minor increase this year compared to fiscal year 1989.

Chairman Cranston. What about the number being furnished outpatient care?

Dr. Gronvall. Again, if I take total outpatient visits, provided by staff of our own facilities on a fee or contract basis, we are projecting that we will provide about 22.6 million outpatient visits this year. That is almost identical, although slightly above fiscal year 1989.

Chairman **Cranston**. Back to the nursing home care, what about the duration of nursing home care compared to a year ago in community facilities?

Dr. **Gronvall**. Did you say in community facilities?

Chairman **Cranston**. Yes.

Dr. **Gronvall**. The length of stay has been declining as we have had both fiscal constraints and sought ways to treat more patients by assisting getting veterans out of nursing homes.

Chairman **Cranston**. So the length of stay is somewhat shorter now in community nursing homes?

Dr. **Gronvall**. Yes.

Chairman **Cranston**. Would you clarify that for the record?

Dr. **Gronvall**. Yes, sir.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The average length of stay in the Community Nursing Home Program increased from 140 to 146 days between FY 1988 and FY 1989. However, there has been a decrease in the length of the planned placement period, as more medical centers moved to a 3- or 4-month placement at VA expense, rather than a 6-month placement.

Chairman **Cranston**. What about the vacancy rate and turn-over rate for doctors, nurses, and other scarce health professionals?

Dr. **Gronvall**. We do keep track of our vacancy rate and turnover rate. At the present time we estimate that something like 5.5 percent of the physician positions that are in the medical centers' budgets are vacant. That figure underestimates the difficulty of physician recruitment, however, because we have been relying on an expanded number of physicians on contract basis, particularly in disciplines where our salary schedules are behind. That, of course, is the basis of the physician pay legislation that we will be submitting.

Similarly, in nursing vacancies we have about held our own between 1989 and 1990, but there are significant problems which, again, are the reasons that we are submitting the nurse pay reform legislation.

Chairman **Cranston**. When you rely on contracts, I guess it is pretty expensive. What about for each of these categories of professionals—I want to ask you the comparison to the situation of a year ago.

Dr. **Gronvall**. In regard to physicians, we now have more contracts in place than we did a year ago. To the extent that contracts are a measure of recruitment difficulty, our recruitment difficulty has increased this year over a year ago.

Chairman **Cranston**. What about the competitive nature of your salary structure?

Dr. **Gronvall**. The salary levels in the VA for physicians and nurses need to be adjusted. That, of course, is why we are submitting legislation. We have used the special pay mechanism for nurses to try to stay competitive, and that has allowed us to keep approximately the same vacancy rate and competitive position this year as last year.

For physicians, I think the pay discrepancy is worse this year than last year, but, again, that's why our budget proposal includes additional funds and legislation to make significant adjustments in physician pay.

Chairman **Cranston**. How does that compare with the situation in DOD?

Dr. **Gronvall**. Well, we stay in touch in a very detailed way with the special pay arrangements in the Defense Department, take that into account and, in a general way, I think at any one time either Defense or VA will be making progress based on legislative initiatives or budget situation.

I think the primary market where we recruit doctors, though, tends to be in comparison with academic medical centers, so we use that as a more important marker in trying to adjust our own salary schedules.

Chairman **Cranston**. Did DOD get a fairly sizable increase just now?

Dr. **Gronvall**. Yes, they did get an increase but—again, they should be testifying to this—my understanding is that the way the details of that worked out they were not viewed quite as advantageously as they had hoped in terms of the adjustment of the various specialties. So while it was an adjustment that was beneficial, it fell short of what they had hoped to accomplish.

Chairman **Cranston**. Well, that obviously is a factor that we should all be taking into account.

What is your appraisal of staff morale now compared to a year ago?

Dr. **Gronvall**. Again, that's a very subjective judgment. I have traveled a fair amount and talked to a lot of people. I would say that because we are looking forward to a much better request for next year and the expectation that we will have our money at the beginning of the year, in that sense the expectation, translated into morale, is better now than it was a year ago as people look forward. A year ago we were declining in our capacity, hoping for a supplemental that came late, and that always creates a great deal of turmoil.

It was then made worse by unhappiness expressed from parts of the Congress with the way we spent the supplemental, even though we only had effectively a month and a half to spend the additional funds.

So we encountered many difficulties managing in that kind of yo-yo environment effect last year. That isn't the case now, so I would say that staff morale has improved.

Chairman **Cranston**. You do think this competitive-pay difficulty has an impact?

Dr. **Gronvall**. Yes. Once again, the knowledge is around the field that we have both nurse pay and physician pay reform legislation ready to go, and the dollar impact is provided for in the 1991 request. So while that is off in the future, the knowledge that the problem is being addressed both with legislation and money I think gives a boost to morale.

Chairman **Cranston**. I think the Congress will be receptive to making substantial improvements in all these areas and you can help get the word around that we are going to be trying to do that.

Dr. **Gronvall**. That certainly is our sense from past hearings and from discussions.

Chairman **Cranston**. Where do we stand on drug stocks compared to a year ago?

Dr. **Gronvall**. I would have to provide that for the record.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The 1989 supplemental allowed the medical centers to replenish much of their depleted inventories. The dollar volume of purchases for the first 4 months of this year are about the same as last year. This is due in part to the supplemental and some improved strategies in the procurement of drugs.

Chairman **Cranston**. What about the replacement equipment and new equipment backlog?

Dr. **Gronvall**. Our backlog, as we document it, has not been improved this year compared to last year. In fact, the documented backlog is slightly greater this year than last year.

Chairman **Cranston**. That's despite the substantial acquisitions that have occurred in the last year?

Dr. **Gronvall**. Yes. At the end of 1989, when we got the supplemental, it provided a very much-needed boost, however, it was not enough money to correct the backlog. The additional funds meant the difference between a disastrous situation and one that was tolerable.

Chairman **Cranston**. How about maintenance and repair?

Dr. **Gronvall**. The same thing there. The projection for the total backlog by the end of this year will be at a slightly higher level than last year. I believe we have been asked for those specific figures and they are on their way to you.

Chairman **Cranston**. Fine.

Finally, what about prosthetics?

Dr. **Gronvall**. There I have some good news to report. Both in 1989 and in 1990, the Congress has added specific funding and, in addition, we have significantly tightened up our own internal management and tracking of those funds to ensure that we meet the need for providing prosthetics services to veterans.

As you know from prehearing questions, we track all of the orders that are more than 5 days old. We have had some difficulty in the exact definition of that tracking system, but we are improving it.

The most recent report I have is from January 1990. In that month we had about 1,000 prosthetic orders that were more than 5 days old. In the previous month, December, there were slightly over 2,000. In November there were about 1,500. So we have been able to make a dent in that and we are going in the right direction.

Our goal by the end of this year is to eliminate the backlog in the prosthetics program. We believe we have about the amount of money this year that will do that job.

Chairman **Cranston**. What does that 1,000 translate into in terms of dollars?

Dr. **Gronvall**. I would have to supply that for the record.

Chairman **Cranston**. Fine.

Dr. **Gronvall**. The total fund, of course, is in the order of $100 million with thousands of items.

Chairman **Cranston**. Fine. In every case where you are submitting information for the record, if you would fill in some figures——

Dr. **Gronvall**. We certainly will.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Based on the average amount of the orders held in fiscal years 1987, 1988 and 1989, the estimated dollar amount of the 1,000 orders held in January 1990 is $899,440. This should not be viewed from the perspective that funding is inadequate for this fiscal year. Most of these delays appear to be caused by temporary staffing shortages due to turnover, sickness, annual leave, etc.

Chairman **Cranston**. I appreciate your candid responses to those questions. I gather the overall situation, both fiscally and in regard to each of these different categories, is that we are really not much better off than we were a year ago.

Dr. **Gronvall**. Well, the way I would describe it, Mr. Chairman, is to say that this year is extremely tight. In fact, within the past day in discussions the term has been used, "We'll get through the year, but just by the skin of our teeth." But, again, we have planned our operation this year based on the funds that we have available.

Chairman **Cranston**. Of course.

Dr. **Gronvall**. I have assurance from the regional directors that we will get through the year based on that projection, and we are looking forward to some growth in the system in 1991.

Chairman **Cranston**. Thank you very much.

Dr. **Gronvall**. If I may, Mr. Chairman, could I just correct one answer I gave earlier in regard to the resource allocation model adjustment.

Chairman **Cranston**. Of course.

Dr. **Gronvall**. We are developing a new methodology this year. The first year where a revised methodology may be used is in 1992 because it requires a year of data and experience to fold into the actual allocation process. I had said that it would be fully reflected in the allocation of the 1991 budget, and I would like to correct that. Again, we will be providing some followup details on the resource allocation model.

Chairman **Cranston**. Fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

VHS&RA is developing a new resource allocation methodology that will have the following features:

The methods proposed will be prospectively oriented and will forecast workload and cost information. This will allow for a better integration between program planning and operations.

The major focus will be the individual patient, and all services associated with that patient (inpatient, outpatient and long-term care). Patient capitation groups are being established such as AIDS and long-term psychiatry in order to encourage medical programs using a "managed care" approach.

Workloads that are not in the patient capitation groups will be classified using case-mix methods similar to those applied by the Health Care Financing Administration (HCFA) prospective payment system (PPS) but with facility-specific forecasted workload and costs. Eventually the majority of the allocations would be based on patient-specific workloads.

The allocations will support and recognize explicitly that sufficient resources are needed for the delivery of quality health care.

Please tell us what portion of the $957 million increase in fiscal year 1991 for medical care will be devoted to improvements in mental health care.

Dr. **GRONVALL**. If we could supply that for the record, it would require calculations.

Chairman **CRANSTON**. Fine. As we look at the budget, there doesn't seem to be any room for an increase in mental health. If you would take a look and see if we are in error in that judgment.

Dr. **GRONVALL**. We will.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

It is estimated that approximately $132 million of the $901 million requested increase to the Medical Care, existing legislation is for mental health care. An additional $8 million could be associated with the $54 million Medical Care proposed legislation request, assuming the mental health portion of proposed legislation is the same as existing legislation. The Mental Health programs include general and specialized psychiatric care, PTSD, Drug and Alcohol Dependency Treatment Programs, Day Treatment, Day Hospital, Mental Hygiene, etc. The additional funding will provide for inflation, payroll increases and budget initiatives in drug abuse treatment.

Chairman **CRANSTON**. Is there an inflation adjustment for the continuation of the $60 million drug abuse add-on carried over into fiscal year 1991?

Dr. **GRONVALL**. Yes. We are projecting, as we look ahead, that both the alcohol and drug abuse programs in 1991 will significantly exceed 1990 total funding—in fact, by more than the inflation adjustment.

Chairman **CRANSTON**. I'd like to focus now for a moment on VA's reorganization proposal. What functions relating to planning, services, and monitoring, such as MEDIPP and quality assurance, were organized at the medical district level?

Dr. **GRONVALL**. Our planning system has been based on the district, and our peer review system has been organized at the district level.

Chairman **CRANSTON**. How will these functions, especially MEDIPP, be organized and carried out under the proposed reorganization plan?

Dr. **GRONVALL**. We have developed a detailed way to handle that. Both of those functions must go on, and both of those functions work best when they are done in the context of a small cluster of hospitals, perhaps five or six hospitals, with each cluster having a referral hospital and then more primary- and secondary-care hospitals in the cluster.

The staff which is doing both planning and peer review will be working for the region, but a number of those staffs will have their offices actually in medical centers scattered throughout the region, and we believe that the planning system and the peer review system will be fully workable, all being the responsibility of the regional director.

Chairman **CRANSTON**. Would you give us a detailed response in writing on that?

Dr. **GRONVALL**. We would be pleased to.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The current Medical District Initiated Program Planning (MEDIPP) will be replaced by a regional planning process under the proposed organization. Planning direction to regions and medical centers will continue to be provided by Central Office. Regions will initiate and oversee the grass roots planning activities of small groups of facilities, organized according to referral patterns. District planners will be replaced by regional planners, responsible for data collection and analysis and coordinating planning efforts among facilities. Some planners will be located in the Regional Director's (RD) immediate office; others will be located in selected medical centers. This outbased placement will afford planners close proximity to the group of medical centers for which they are responsible. Regional Planning Boards will continue to review all plans, establish priorities and identify opportunities for shared resources.

The current MEDIPP cycle will be completed for the seven region organization. The next cycle will be based on the new, approved organization structure. Current requirements for a 1-year planning cycle will be reviewed along with the feasibility of extending the cycle to 2 years.

The Medical District Peer Review Organization (MEDIRPO) similarly will be handled as a regional process. Currently, specific quality of care studies are designed by MEDIPRO Boards. Data collection for the studies is performed by clinical evaluators located in the medical centers. MEDIPRO Boards analyze data and report back to the facilities and regional Quality Assurance (QA) staff. Modification of this process, as well as restructuring of the total regional QA program, has been planned. Regional QA activities will be integrated into a total quality management approach, with RDs assuming operational responsibility for implementing QA policies and programs, monitoring quality management policy compliance, and providing education and consultation to medical centers. MEDIPRO Boards will be replaced by regional review boards structured to conform with the new QA organization. Data collection will continue to be performed by medical-center based clinical evaluators.

Chairman CRANSTON. In the context of VA's recent history of budget shortfalls, we often ask about veterans who have been turned away from VA medical care services. Please tell me the operational definition the Department uses for what we call "turnaways."

Dr. GRONVALL. We provide, on a monthly basis, an exquisitely detailed report of all veterans who apply for care, on an all-inclusive basis, and then what happens to them. A number of veterans come to us, are evaluated, turn out to be veterans whose care is discretionary, and for either resource-constraint basis or the unavailability of a unique kind of service the VA facility at which the veteran applies does not provide the care. We then have our social work people assist the veteran in trying to seek care in the private sector.

If that is a definition of turning away, then a significant number of veterans whose care is discretionary are being referred to community health-care resources.

Chairman CRANSTON. Do all VA units use the same definition?

Dr. GRONVALL. Yes. We have a nationwide system of eligibility and a national definition of mandatory categories of care. We use the term "category A" as being equivalent with mandatory. It is much more complicated, of course, because the statutory definition of entitlement for inpatient and outpatient care differs. And then, beyond that, we have defined a number of categories as mandatory.

Chairman CRANSTON. How would you classify a veteran who is not explicitly turned away, under that definition, but is given an appointment 6 months later for something he or she believes requires prompt attention?

Dr. GRONVALL. That, of course, comes down to a difference in judgment between the patient and the physician. In every case where an appointment is scheduled with a long lead time, that is based on a physician's determination that the nature of the medical problem is such that that is an acceptable way to provide the care. If the veteran believes that is unacceptable, in many cases the veteran will turn elsewhere for care.

But we insist that if the physician believes the care must be given immediately or at an earlier time and the veteran has a mandatory level of eligibility, we then provide the care or arrange for it and pay for it.

Chairman **Cranston**. Would you be able to provide to us for the record—I know you won't have them at your fingertips—statistics on how many such veterans are eventually seen at appointments that are over 90 days away, and how many don't show up for those appointments?

Dr. **Gronvall**. I believe that we have such data, and we will supply whatever we have. Yes. sir.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The information requested regarding the number of veterans scheduled for appointments over 90 days in the future and the number of these veterans who either report or fail to keep these appointments is not maintained.

Chairman **Cranston**. Is there any way of knowing whether veterans who do not keep distant appointments seek care outside the VA system or go without what they consider timely care?

Dr. **Gronvall**. We have done only limited investigations of that, and the service organizations have brought that to our attention occasionally with anecdotal examples. We do not have comprehensive data that would be satisfying, but we do have some indicators. We could provide what information we have.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

There is no data maintained to determine the number or percentage of veterans who do not keep appointments scheduled over 90 days in the future.

Chairman **Cranston**. If you'd do that, I'd appreciate it. And I'd also like to ask you to prepare a detailed report to the committee, to the best of your ability, which includes whatever statistics are available on veterans who don't receive VA services according to distinctions that I have raised in this set of questions.

Dr. **Gronvall**. We will certainly do so.

Chairman **Cranston**. Fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

When a veteran applies for medical care and following a clinical evaluation if it is determined that the applicant is not in need of admission, nor requires treatment to obviate hospital care, the veteran is determined not to be in need of further medical care. During fiscal year 1988, there were 2,884,341 applications for care. Of this number 81,839 (3 percent) of the applicants were determined not be in need of care. During fiscal year 1989 there were 3,307,510 applications for care. Of this number 99,581 (3 percent) were determined not to be in need of care.

Chairman **Cranston**. What is the current official policy of Central Office on the availability of inpatient care to veterans in categories A, B, and C?

Dr. **Gronvall**. If a veteran is in category A, according to the means test, or service-connected status, and requires hospital care, we provide it or arrange for it in another facility and pay for it.

Chairman **Cranston**. Is that a written policy?

Dr. **Gronvall**. Yes.

Chairman **Cranston**. What about for outpatient care for each category?

Dr. **Gronvall**. We follow the statutory eligibility criteria there, which are complicated because not all veterans who are in the mandatory category A definition for hospital care are mandatory for outpatient care. For example, veterans with service-connected disabilities less than 30 percent in category A are not entitled to outpatient care for all medical conditions.

So, again, we have written nationwide eligibility policies that take into account the statutory eligibility criteria.

Chairman **Cranston**. Jon Steinberg has a followup question here.

Mr. Steinberg. Dr. Gronvall, I believe that you—and Mr. Carroll may want to address himself to this also—I believe you have indicated twice that if you don't have a bed for a veteran—and I think you said a similar thing as to outpatient care earlier, but at least as to inpatient care—and he is a mandated veteran in category A, then you pay for it. My question is: under what authority would you pay for a contract hospital bed for a non-service-connected veteran?

Dr. **Gronvall**. My understanding—and then perhaps the General Counsel should speak to it—in category A, if the veteran requires hospital care, we can either do it in the VA, refer the veteran to a Defense Department hospital, or, if necessary, arrange hospitalization and pay for it. But Mr. Carroll may correct me on that.

Again, if I am in error, I don't handle these details on a day-to-day basis. If that is erroneous, we will surely correct it for the record.

Chairman **Cranston**. Did you have any comment, Mr. Carroll?

Mr. **Principi**. I believe there is a question with regard to that response. I do not believe there is authority, nor was it intended by the Congress that category A non-service-connected are entitled to fee-basis care in the private sector. If a bed is not available, we refer that veteran to another VA facility or a DOD facility, but there is no authority for us to provide that care in the private sector.

Mr. **Steinberg**. I think the reason, perhaps, that you smiled slightly, Tony, is that you remember the statement in the joint explanatory statement when these entitlements were established that there was no change intended as to the contract areas.

Mr. **Principi**. That's correct

Mr. **Steinberg**. So Congress was very explicit on that. Thank you.

Dr. **Gronvall**. I appreciate being corrected, although it is embarrassing. I said I do not handle those details on a day-to-day basis. We do have national criteria that are anchored in the law, and I'm happy to have the record corrected so promptly.

Chairman **Cranston**. If you would furnish us with a copy of that written policy I'd appreciate it.

Dr. **Gronvall**. We will be pleased to.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Pages 4-10 through 4-12 of M-1, part I, chapter 4, "Admissions—Hospital and Domiciliary Care," regarding eligibility for inpatient care are attached. Also attached is VHS&RA Circular 10-88-79, which contains the written policy for outpatient medical care.

[The submitted attachments are retained in the committee files.]

Chairman CRANSTON. And also would you give us a written report with a table listing each medical center and its written policy regarding inpatient admissions and outpatient visit scheduling for each category of veterans.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Copies of the local medical center policy regarding inpatient admissions and outpatient visits scheduling for each category of veteran are not maintained within VA Central Office.

Chairman CRANSTON. Do you expect these formal and informal policies to change in fiscal year 1991?

Dr. GRONVALL. In fiscal year 1991 the budget, as requested, will provide for some additional staff and a higher level of patient care. The full answer to your question, however, depends on demand from veterans in various entitlement categories. So I think it will not be until we are into 1991 that we will be able to say with any certainty whether that situation changes a little or a great deal.

Chairman CRANSTON. Ed, I'd like to get back to you with the next question.

Our review of the budget for 1991 found no increases in resources devoted to the treatment of PTSD. As I see it, the tremendous need of the Vietnam veteran population has been clearly established by the quite exhaustive 4-year, $9 million study conducted by the Research Triangle Institute.

That study found that almost 850,000 veterans of the Vietnam conflict are in need of treatment for full-blown PTSD or some symptoms of it, and these findings haven't really ever been questioned.

Although I applaud your efforts in obtaining a vast improved budget request for fiscal year 1991, I find it difficult to accept that out of the almost $1 billion increase for medical care in fiscal year 1991, no additional funds are to be allocated for PTSD treatment. The problem has been identified. It is a problem directly related to veterans' service in a combat theater. And the few VA resources devoted to treatment are constantly plagued by long waiting lists.

Last year in this committee's hearing on the fiscal year 1990 budget you expressed your view that PTSD deserves a high priority. In light of the tremendous unmet need of veterans with PTSD, can you explain why the budget proposal has no additional funds for that purpose?

Secretary DERWINSKI. As you know, Senator, the figure that you have before you for the 1991 budget is the one that was hammered out on consultation with OMB. We understand your point. We recognize that need. We would like to take a look at improving our outreach to Vietnam veterans and also to maintain and, wherever practical, improve the services specifically aimed at those who are suffering from PTSD. So we have no philosophical or general quarrel with you. We do have the budget adjustments we have had to struggle with.

Chairman **Cranston**. With regard to the waiting list that exists at these 16 inpatient PTSD units—up to 20 months, I understand, at the Tacoma, WA, facility—what steps has VA taken to determine the causes of such lengthy waits?

Dr. **Gronvall**. We, of course, keep the data about each of the units, the demand, and the length of time. I think that the Tacoma program is one of the best that we have had and one of the best developed, and it has attracted a much higher level of applicant activity, and so that is a factor as to why the waiting list is longer at that medical center.

We are expanding our PTSD programs this year, of course, and so we hope to improve the situation.

Chairman **Cranston**. The committee has received reports from the field that since reimbursement did not fully cover the cost of treating patients for PTSD on an inpatient basis, facilities began conducting short intake assessments of 2 or 3 days, which then is reimbursed at a level above the cost to the facility.

With a positive reimbursement, the facility is then able to treat patients in 1- to 3-month programs later and come out essentially even under the resource allocation method. Does this accurately describe what has happened?

Dr. **Gronvall**. I can't, of my own knowledge, say that is accurate. I have heard that comment, but don't know whether it has been reviewed or validated.

Any funding model that is based on an estimate of the cost of providing various kinds of care, using DRGs, or whatever model, is always subject to being slightly above or slightly below in various categories. We continually make adjustments in those funding models to try to deal with such problems as they are brought to us. I would have to have someone review that to respond further to your question.

Chairman **Cranston**. If that is the case—and perhaps you should respond in writing when you look into this—I wonder if that would have contributed to the waiting list? You could respond to that when you look into that.

Dr. **Gronvall**. Let us respond.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

It is clear that some Specialized Inpatient PTSD Units (SIPUs) include in their clinical programs an initial assessment period of several days prior to actual entry into the treatment program. While fiscal concerns may have some bearing on the development of this approach, there is also a clinical rationale. Patients can be thoroughly and efficiently assessed through an intensive inpatient screening period to determine their appropriateness for SIPU care. There is no indication that resources gained during the assessment admission would offset losses from the subsequent treatment admission. The phenomenon of waiting lists for SIPU admissions appears to be related to numbers of patients assessed as needing specialized inpatient care compared to the numbers of beds available to treat them. This expression of continuing need for Post-traumatic Stress Disorder (PTSD) care is one of the reasons for the continuing expansion of Department of Veterans Affairs (VA) PTSD services that in FY 1990 includes 20 new PTSD Clinical Teams (PCTs, which provide outpatient care) and 4 new Specialized Inpatient PTSD Units (SIPUs for inpatient care). Finally, it must be noted that identification of resources allocated for PTSD care on the specialized units is difficult, due to the current resource tracking system. Resource allocation is based on the case-mix of a medical center in relation to other Veterans Administration Medical Centers (VAMCs) in the nation.

The acute care Resource Allocation Methodology is based on the Diagnosis Related Group (DRG) system. All discharges from a VAMC for DRG 427 include PTSD and other anxiety disorder diagnoses. All PTSD discharges from a VAMC with an SIPU include discharges from the SIPU and from other units (presumably mostly psychiatry units) in that VAMC. The resource tracking system does not break down resources in a unit-specific way that can be used to show costs vs. resources for SIPU care. This information should become available, along with clinical outcome data, from the systemwide PTSD program evaluation that is being developed by Mental Health and Behavioral Sciences Service. It must also be noted that VA reporting of costs to treat PTSD currently, even if this could be derived from the current system, would primarily reflect care in non-SIPU settings. Patient Treatment File data for FY 1989 reveals that 68.3 percent of PTSD discharges come from VAMCs without SIPUs. Most inpaitent PTSD care in VA is not provided on SIPUs, and in general, most lengths of stay for PTSD care on general psychiatry units are within the DRG trim points. Most PTSD inpatient care is shorter than that found in SIPUs (10 of 15 SIPUs have treatment programs whose duration is at least 12 weeks). This is logical since referral to an SIPU implies intensive, extended inpatient care for the most severe and complex cases of PTSD which cannot be adequately treated on general psychiatry units.

Chairman CRANSTON. Has VA explored other methods of reimbursement or funding for these programs?

Dr. GRONVALL. Yes. We have, in PTSD and AIDS and spinal cord injury, explored many kinds of funding and reimbursement methods and then adopted what we thought was the best way to handle each program, taking into account not only the individual program, but the overall needs of each of the medical centers.

So I would say, as a generalization, every funding model that we adopt is a compromise between incompatible goals. None of them make everybody happy, but we try our best to have a total funding mechanism that recognizes the total responsibilities of each of the medical centers and fund availability.

Chairman CRANSTON. Jon Steinberg has a followup question.

Mr. STEINBERG. Dr. Gronvall, would it be possible, as you reevaluate the RAM during this fiscal year for implementation next fiscal year, to look into whether there might be a way to handle reimbursement for PTSD treatment programs that would not have the effect of skewing the treatment approach that is taken?

Dr. GRONVALL. Absolutely. And I would add to that, though, a caveat that we feel it is our responsibility in every category of care of veterans to be sure that the funding model provides an incentive for what we believe at the time is the best way of providing the care.

You used the term "skewing the treatment plan." I would say it is a positive intent of a funding model to influence treatment of veterans in the most positive direction. It is a different way of looking at the same factor. I would not want to commit that we would try to adopt a funding mechanism that would not influence the way the care is delivered, because that, in fact, is the basis of the funding model.

Mr. STEINBERG. We certainly understand that. The reason that I used the word "skew" was because the reports that we had received from the field indicated that the primary reason that they adopted the treatment approach of a short-term intake followed by a second waiting list and a longer-term treatment program was because of the reimbursement method. If that is incorrect, then we would hope that you would correct that for us, and in reporting back to us on this issue tell us what your preferred treatment methodology is that you are attempting to influence positively in the RAM formula that you develop for PTSD.

Dr. GRONVALL. Yes. And let me respond to that positively to say that in this area, as in any other, if we find that the funding model disadvantages or interferes with what is the best way to provide the care, then we are happy to make the correction, if it is possible, to provide a positive incentive rather than a disincentive to the best kind of care.

Mr. STEINBERG. By what date do you think you might be able to give us a report back on this particular issue?

Dr. GRONVALL. We will be supplying a great deal of material soon after this hearing. Because of the complexity of that kind of question and the fact it is caught up in a broader review of the RAM, I think what we ought to soon supply to you is a date by which we think we could have that done.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

We have established incentives for short lengths of stay in our acute care medical, surgical and psychiatric bed services consistent with the standards used in the private sector. There are patient care settings other than acute medical, surgical and psychiatric settings in which longer length of stay patients can be accommodated without the incentive for an early discharge, e.g., intermediate medicine and nursing home care units. In addition, we have a "high cost outlier" funding method for inpatients whose length of stay on acute medical, surgical and psychiatric bed services exceeds an upper boundary. While we believe that there have been suitable alternatives for treating PTSD patients, there are some facilities which may not have had access to all of these various treatment modalities.

The issue as to whether the normative clinical practice patterns of facilities are appropriate is one which requires thoughtful analysis and clinical insight. VHS&RA has established a steering committee to oversee development of the resource allocation models. The committee consists of key management and clinical staff from VA Central Office and the field. In addition to the steering committee, technical advisory groups have been established to develop the technical aspects of the new resource allocation process. Therefore as part of this process all aspects of long-term psychiatry including PTSD patients will be reviewed by the Technical Advisory groups in terms of their clinical requirements and resource needs.

Chairman CRANSTON. The committee has received reports indicating that VA faces serious problems throughout the system in recruiting and retaining qualified psychiatrists. I am very concerned that the cuts in medical research opportunities in fiscal year 1991 will serve only to exacerbate the problem of attracting mental health professionals to the VA work force.

The February 19, 1990, article in the Federal Times states that 1 in 5 VA psychiatrist positions are now vacant. Is that an accurate figure?

Dr. GRONVALL. I think that statement depends on a definition of what is a position and what is vacant. I do not have a figure at my fingertips based on the definitions we use. We will be happy to supply that. We do have a serious problem in recruitment of psychiatrists. I'm not trying to minimize that in any way. But I would not be prepared to agree with that figure.

Chairman CRANSTON. If you would give us that for the record, I'd appreciate it.

Dr. GRONVALL. I would be pleased to.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

As of December 31, 1989, there were 101 full-time vacancies and 29 part-time psychiatrist vacancies reported in the medical centers. This represents approximately 8 percent of the 1,300 full-time positions and 4 percent of the 728 part-time positions. We believe these vacancies may be somewhat under reported, due to the fact, once a position has been vacant for a year or more, the vacancy may be converted to other uses. For instance, if a medical center cannot hire a psychiatrist after a year of recruting, they may fill the vacancy with a physician assistant, or they may allow another service at the medical center, which can attract candidates, to use the vacancy. These types of situations would not be accounted for in our current vacancy reports. A new reporting system being implemented by the Department is designed to improve the accuracy of vacancy reports. The results of this new survey will be available during May 1990.

Chairman CRANSTON. Please describe, in general, what the current situation is with regard to the recruitment and retention of psychiatrists and other mental health professionals and the reasons for any difficulties.

Dr. GRONVALL. As a generalization, I think psychiatry is one of the physician categories in which we have done less well this year than last year and the year before in terms of our competitive position. Some of that has been an improvement of psychiatrist salaries outside the VA in State hospital systems, private psychiatric settings, and academic centers, and we have not been able to keep up. We believe that the adjustments that will be in our physician pay proposal will take that into account and will enhance our ability to improve our recruitment and retention of psychiatrists.

Chairman CRANSTON. Does your proposal make any special adjustments for psychiatrists?

Dr. GRONVALL. Well, the proposal is based on a review of every discipline, and it proposes adjustments across all of the medical and surgical specialties based on our best judgment of where the problems were and how best to deal with the problems. No individual discipline was taken as a categorical requirement to make a full adjustment because we had to balance the total needs of all of the disciplines.

Chairman CRANSTON. I want to welcome Senator Thurmond at this stage and yield to him for any comments, questions, pronouncements, whatever.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Thank you very much, Mr. Chairman.

Mr. Chairman, it is a pleasure to be here today to receive testimony on the problem of the Department of Veterans Affairs budget for fiscal year 1991. I want to take this opportunity to thank you and the ranking member, Senator Murkowski, for scheduling this hearing. I also want to extend a special welcome to Secretary Derwinski and his fine staff, as well as the other witnesses here today.

Mr. Secretary, it has been a little over 1 year since the VA was elevated to Cabinet status, and I want to commend you on the fine job you have done over the past year. You have assembled an excellent staff, and I am pleased with your enthusiasm and the hands-on attitude which you have exhibited at the Department.

Mr. Chairman, as we consider the budget for our veterans, we must also be mindful of our huge national debt which is currently $2.9 trillion, because it is in our national interest to continue to reduce the deficit. We have many tough choices to make. We again must weigh competing demands for limited Federal resources; at the same time, we must ensure that necessary Federal programs are not unreasonably curtailed.

I want to commend you, Mr. Secretary, on the $30.9 billion VA budget for 1991. I am aware that this represents the largest budget ever. I am particularly pleased with the $1 billion increase in the medical care budget; however, in all frankness I must indicate my concern with the $14 million decrease in budget authority for medical research.

As you know, I have a strong interest in the research that takes place at the VA and want to reiterate my special strong interest in a proposed joint research venture between the VA and the Medical University of South Carolina. In this particular case I again want to say the State is willing to offer the land and pay half the cost for this venture. In short, I believe it will represent a wise investment for the Federal Government. It is the only instance I know of where any State has offered to put up as much as we are offering to do here.

Mr. Chairman, again I want to thank you for scheduling this hearing. I want to say that I just have a few questions since Senator Murkowski couldn't be here.

Mr. Secretary, your budget also proposes to expand a copayment program to category B veterans and to collect for prescription drugs. Would you envision collection occurring by way of a billing process or at the time of delivery of services? What is your rationale for this decision?

Dr. GRONVALL. Senator Thurmond, as we have reviewed all of the projections for ways to balance the demand for care and the fiscal resources, a number of billing arrangements and copayment arrangements have been proposed in the President's budget. We would be pleased to followup through the details of the legislative proposal to supply the detailed rationale underlying each of those projections.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

At this time no decision has been made regarding whether the collections would be made at the time the services are received or a bill prepared and processed after the date of service. The VA will accept cash or credit cards for payment of these bills. A computer billing system must be developed if a bill is to be presented at the time the service is rendered.

Senator THURMOND. Mr. Secretary, with an estimated $1 billion increase in medical care for fiscal year 1991, what percentage of category B and C veterans will this allow you to care for?

Dr. GRONVALL. I believe we are not able to provide a specific percentage figure. The additional staff and capacity will allow us to expand the number of patients we treat next year, but the answer to that question will depend on what happens to demand—namely, the number of veterans coming to us for care. While we can project with some certainty how many veterans we will be able to treat with the additional staff and dollars, only experience will tell what the breakdown will be in the various eligibility categories.

Senator THURMOND. Mr. Secretary, I know that the more money the VA has the more veterans it can treat. With that in mind, can the VA manage this fiscal year without supplemental funding? Is the VA proceeding with its planning on the assumption that no supplemental funds will be forthcoming?

Secretary **Derwinski**. Yes, Senator. That's exactly our position. We feel that, as we have often stated, we have been in the last few years on sort of a roller coaster where we start off with a figure that is too low, then we have to guess and wait for the supplemental, and then the latter part of the year we have to readjust because the funds come late. We feel for fiscal year 1991 we have a very appropriate and, we think, commendable, upfront figure that will permit very intelligent and effective planning. Dr. Gronvall earlier referred to the fact that this is actually perceived in the field and is received as a morale builder because there is far less uncertainty because of that upfront figure than there had been in the past.

So we feel that in fair measure the 1991 budget request doesn't put us in a position where we have to ask for a 1990 supplemental.

Senator **Thurmond**. Mr. Secretary—and this is the last question—do you have an idea when the Department of Veterans Affairs is likely to submit its report to this on Veterans' Affairs on the joint VA/Medical University of South Carolina Research Center?

Secretary **Derwinski**. The university and the VA are meeting now to develop a plan on that joint venture, and that plan is due to us in mid-March. It is my hope that shortly thereafter we could have that plan to the Secretary for decision and back to you hopefully by April of this year.

Senator **Thurmond**. I want to thank you for your careful study of this important matter.

Again, I want to thank all of you for the good job you are doing.

Secretary **Derwinski**. Senator, if I may have your attention for a minute, I just wanted to correct the record. You very politely complimented me on the 1991 budget figure that we have, but I must tell you that it was really the work of Dr. Gronvall, Tony Principi, and Tony McCann, our Assistant Secretary for Finance. They did most of the in- fighting with OMB and they deserve the credit more than I do.

Senator **Thurmond**. Thank you very much.

Mr. Chairman, I would like to ask that the statement of Senator Murkowski be inserted in the record. It is also available to the press on the press table.

Chairman **Cranston**. Thank you very much.

[The prepared statement of Senator Murkowski appears on p. 138.]

Chairman **Cranston**. Ed, I would like to say your modesty is very appropriate in responding to that question, but actually I suspect your visit with President Bush in the White House had quite a bit to do with the outcome, and I thank you for that.

Secretary **Derwinski**. I'd rather be accurate and modest than overstate my influence.

Chairman **Cranston**. It shows the virtue of having a Cabinet post and you in that Cabinet post.

In the area of treatment for homeless veterans, it is disappointing to see that VA's fiscal year 1991 budget includes no additional funding for the two VA homeless veteran programs. Homelessness in our society is a persistent, serious problem—one that both the President and I know the American people are very concerned about and I believe needs more and more attention until it is resolved.

Veterans comprise an inordinately high percentage of the homeless population, as we all know. VA's recent report on its homeless program indicates that between 29 and 47 percent of homeless males are veterans. The needs of these veterans are immediate and they are severe, and the flat rate of funding for fiscal year 1991, which translates into a programmatic decrease, seems to me to be very much out of sync with the Nation's priorities and insufficient in view of our special responsibilities to truly needy veterans.

Can you explain why the programs for the homeless are not to receive any of the $1 billion increase in fiscal year 1991?

Secretary **Derwinski**. Senator, let me just say that we are caught in a situation where we have been performing, we believe, with a certain amount of imagination and attention to a subject that has been neglected elsewhere, in that we focused on the problems of the homeless long before other agencies and departments of Government did so.

May I add that in the same way we think we have been very effective leaders in combating drug addiction, because it has been a normal part of our service to veterans.

Now, what we have done in the inter-agency structure—Secretary Kemp chairs the Inter-Agency Task Force on the Homeless. We have cooperated totally. We have worked within that structure to maximize our input. But we really have, on our own, been aggressively attempting to reach those veterans, and while I'm sure there are specific pockets where we have been less successful than in other areas, we feel we have an effective program in place and that we have been ahead, rather than behind, the curve in addressing those special veterans' needs.

Mr. **Principi**. If I could just add, I believe that really part of that $1 billion increase will be used to care for the homeless, because when the homeless come to us and they occupy our domiciliaries and other pilot projects—our HCMI program—they come to us with other disabilities. They come to us with AIDS. They come to us with drug abuse. And they come to us with medical problems that are addressed in our medical care system. So those homeless veterans are occupying our acute care beds and our other beds, as well, so I do think we are doing a great deal for them, Senator, and we will continue to do so.

Chairman **Cranston**. I know you have been doing your best with the resources you have, but given the magnitude of the problem, the many veterans that are homeless still, and the feelings of the American people about this, I wonder about a policy where there is really a net decrease when you take an inflation factor into account.

Mr. **Principi**. We will certainly look into that allocation.

Chairman **Cranston**. The homeless chronically mentally ill program places two outreach workers at each of its 43 sites. It certainly seems that in large, metropolitan areas with corresponding large numbers of homeless veterans, such as New York, Houston, Chicago, and San Francisco, two outreach workers are inadequate to really cope with the need. Does VA contemplate increasing the number of FTEE of such large, urban sites in fiscal year 1991?

Dr. **Gronvall**. We don't have a specific plan and have not made a commitment to do so. We are actively evaluating both of our specific homeless programs at all times and look for ways in which they need enhancement. For example, we hope to activate six additional domiciliary homeless programs this year and expand the number of beds devoted to that program.

The number of staff specifically working in a VA program understates the effectiveness in the sense that we have developed those programs in cooperation with community resources. So we will have a couple of VA people working in close collaboration with local and community resources so that as local homeless programs are operated, those homeless individuals who turn out to be veterans then can be referred into the VA. It would not be an accurate portrayal that we only have two people in the whole city of New York working on the homeless issue. Those are the specific people as a contact point between the VA programs and the community resources.

Chairman **Cranston**. In connection with the reevaluation that Tony referred to, if you would take a look at that FTEE situation we'd appreciate it.

Dr. **Gronvall**. I would be glad to.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

It is true that 41 of VA's Homeless Chronically Mentally Ill (HCMI) Veterans Program started in FY 1987 with 2.2 FTEE. The HCMI Program at VAMC Washington, DC was activiated with 4.2 FTEE as a pilot program. Also, VAMC West Los Angeles, CA was given an extra FTEE and funding to hire a homeless veteran for outreach activities. Over the first 2 years of the program, we found that as more homeless veterans were placed in residential treatment, the responsibilities of the two clinicians assigned to each program shifted from outreach to case management. We also continued to see staff turnover in the program and found that one of the reasons was staff burnout. At the end of FY 1989, all HCMI programs were invited to submit applications and justifications to convert funds for contract residential treatment to funds that could be used to support additional staff. Fourteen HCMI Programs requested this exchange and 13 of the requests were approved. Each of these 13 sites received additional FTEE and additional personal service funds to support the FTEE. In addition, the followup component of the national evaluation was completed in FY 1989. The nine FTEE assigned to nine selected HCMI Programs for this phase of the evaluation have now been reassigned to outreach and case management functions. Some of these FTEE remained in the HCMI Program at the original evaluation site while others were moved to other HCMI programs to support pilot initiatives. For example, the HCMI Program at VAMC New York, NY is activating a drop-in center and has been given four additional FTEE and staffing dollars to support this new effort. The HCMI Program at VAMC New Orleans, LA has developed a relapse prevention program for homeless veterans with substance abuse disorders. Additional FTEE and funds have been provided to support that initiative. Of the total funds dedicated to the HCMI Program in FY 1989, 29 oercebt were used to support 113.8 FTEE assigned to the 43 sites. In FY 1990, 34 percent of the total funds are being used to support 124.9 FTEE.

Chairman **Cranston**. VA's budget submission indicates that the funding level for the readjustment counseling program will remain level in fiscal year 1991. I am concerned that with no increase for either inflation or salary the readjustment counseling will inevitably experience a programmatic decline. I understand that 5 years ago the readjustment counseling program budget included $960,000 for travel. In today's dollars, the current level of $900,000 will buy far less travel than 4 years ago. Since the number of veteran centers has expanded over these years, isn't there a need for increased travel funds for monitoring and for training?

Dr. **Gronvall**. Yes, but that same comment applies basically to every program we are operating where there has been any program growth. While those of us in medical/administrative responsibilities believe it is valuable to travel, generally the people who make appropriations and write budgets don't smile on such administrative costs. So we have had to accommodate to very stringent travel support budgets.

We take the travel funds available each year, allocate them on our best judgment, but then make adjustments during the course of the year. That happened last year with the readjustment counseling program. We started the year with an unrealistically low travel budget, made a major increase during the course of the year, and again we would commit to operate on that basis every year to take all the travel money that is available, look at all the programs, and try to tailor the allocations as best we can to do the job. I agree totally with the intent of your question and we will manage it in that way.

Chairman **Cranston**. With the increase in the overall budget, it seems to me this is an important program. You just have to try to keep pace.

Dr. **Gronvall**. We will review that.

Chairman **Cranston**. What funding would be necessary to meet fully the travel needs of the readjustment counseling service?

Dr. **Gronvall**. I'd have to respond for the record.

Chairman **Cranston**. OK. If you could do that by the middle of next week on that particular one I'd appreciate it.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The deficits in the RCS travel allocations with respect to meeting minimum key objectives, in FY 1990, is $42,000. Addition of this amount to the base figure of $900,000 for FY 1991 will ensure essential management activities.

Chairman **Cranston**. With regard to readjustment counseling fee care, there was a severe shortfall in fiscal year 1989. What is the current allocation for readjustment counseling fee care in fiscal year 1990 and what is the proposed allocation for fiscal year 1991?

Dr. **Gronvall**. We'll have to supply that for the record.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The FY 1990 allocation, and the projected allocation for FY 1991, for the Readjustment Counseling Service fee contract program is $5.0 million for each year.

Chairman **Cranston**. Under your flat budget request for this program in 1991, won't contract fee dollars likely be depleted to cover inflation in direct care costs?

Dr. **Gronvall**. I don't know. Again, we would reply for the record.

Chairman **Cranston**. Fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

For FY 1990, a policy decision was made by the Veterans Health Services and Research Administration to fund increased cost and usage (uncontrollable increases) for vet centers, and to add additional funds to bring the contracts program back to $5.0 million and maintain it at that level.

Chairman CRANSTON. According to VA's fiscal year 1990 detailed operating plan regarding prosthetics, the approximately $16 million increase between that plan for this year and the President's budget submission for next year is due to a concerted effort to reduce the prosthetics backlog. I applaud that effort. I do have some specific questions.

In the view of Central Office, when does a prosthetic request become part of the backlog?

Dr. GRONVALL. If it has been more than 5 days between the time the prosthetic device is ordered or identified as a need and the time at which a definitive action has been taken that will make it available at the appropriate time.

Again, in one of the prehearing questions we were asked some questions about that. The measuring sticks that we have been using are not adequate to provide a very precise definition, and we are working with our prosthetics people and our medical center people to try to refine that measuring stick this year so that we will have a much more precise definition.

Chairman CRANSTON. When will we get the answer to that prehearing question?

Dr. GRONVALL. Again, I think in the material that we send over following the hearing we ought to define how long it will take us to improve the tracking system that we have in place.

Chairman CRANSTON. Under Central Office standards, what is the current prosthetics backlog?

Dr. GRONVALL. I have with me only the documentation about the number of orders more than 5 days old. I'd have to supply the backlog dollar figure for the record.

Chairman CRANSTON. We did ask for that a couple of weeks ago in the prehearing questions.

Dr. GRONVALL. I believe it is in a detailed prehearing question. We have a very thick stack of prehearing questions that we have provided enormous amounts of detail on questions such as that.

Chairman CRANSTON. Well that is one we want as soon as we can get it.

Would you also let us know what the backlog will be for prosthetics at the end of 1990 and 1991 for the record?

Dr. GRONVALL. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

VA is committed to managing the provision of prosthetic services, so that backlog of orders are held to a minimum. At present, we have no objections for an end of year backlog for FY 1990 or 1991. We are in the process of defining the exact parameters of a delayed order which will improve the reports on this important issue. This should be accomplished within the next month. As to the dollar value of those orders currently classified as being delayed, we estimate the dollar amount of these orders to be $899,440. However, the dollar amount of these orders should not be viewed from the perspective that funding is inadequate for this fiscal year. Most of the delays in ordering prosthetic services appear to be caused by temporary staffing shortages due to unexpected turnover, sickness, annual leave, etc.

Chairman **Cranston**. Ed, I understand that you are now considering a modification of the prioritization methodology for major construction projects to increase the weight given seismic considerations. What is the status on that?

Secretary **Derwinski**. I believe that David Lewis, our Assistant Secretary, has that under immediate review.

Chairman **Cranston**. I congratulate you, Ed, on the sizable increase in the very important area of minor construction. To help put such a request for $145.6 million in perspective, however, could you tell me what kind of backlog you have on minor projects which have been funded through the design phase but for which construction funds will not be available under your 1991 request.

Mr. **Principi**. We will have to provide that for the record, Mr. Chairman.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

MINOR CONSTRUCTION BACKLOG

The backlog of projects in the minor construction program, which have been approved for design, but for which construction funds will not be available under our FY 1991 request, totals $85 million.

Chairman **Cranston**. How do you explain the 30 FTEE reduction in the Office of Facilities for fiscal year 1991 in the face of an increased construction effort?

Mr. **Principi**. We are undertaking a complete functional and staffing analysis for all central office organizations and selected staff offices in the field. We have a very large Central Office construction staff, and we believe the reduction will not in any way impair our construction activity. The result would be better management of our FTEE work load levels.

Chairman **Cranston**. Ed, I'm concerned about the $16.6 million that you have requested under GOE and the $22 million under major construction for Central Office building renovation. That strikes me as a lot of money at a time when I believe the GOE account is short of funding for the national cemetery system equipment backlog, for vocational rehabilitation counselors, for loan servicing, for claims adjudication, and for certain ADP needs.

Have you personally satisfied yourself that this entire $38.6 million renovation and refurbishing project really needs to be done in fiscal year 1991?

Secretary **Derwinski**. Senator, our building is a disaster. In fact, it borders on being a safety hazard. I was stuck in an elevator this morning, and——

Chairman **Cranston**. I'm glad you got here.

Secretary **Derwinski**. Well, it was touch and go for a moment. I didn't want to break your heart. [Laughter.]

But I'd invite you to come down. Just walk in in the middle of the day and see some of the chaos that we are faced with because of that very antiquated structure we are in. While Bob Schultz is in our office directly involved in the renovation—he's one of our crackerjacks, and he's doing this. He has been told to do it in as practical and as cost conscious manner as possible. But I assure you we have a dire need for rehabilitation of that structure.

Chairman CRANSTON. At almost $40 million that does seem to be a pretty large figure given the other needs, but you live with it and we don't.

Could you please provide for the record a detailed description of the office components and number of employees involved in the renovation, the expenditures for each component involved and per employee, exactly what changes will be made and why they are essential? How much will be spent for new furnishings and decorations as contrasted with the basic realignment of space? And could we receive this by mid-week?

Secretary DERWINSKI. We will supply as much as we can.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

CENTRAL OFFICE RENOVATION PROJECT

1. A detailed description of the office components affected by the Prospectus Project and costs per employee are contained in the VA Costs by Component and per Employee Chart.

Changes that will occur include removal of interior walls, corridors, and other areas to allow 75 percent open office space, to accommodate modular-style furniture. With these changes, VA plans to accommodate 400 additional employes in the headquarters building with projected annual lease savings of over $4 million per year.

In FY 1991, the $16.6 million GOE request includes costs associated with the renovation, not actual construction costs. Over half these costs would be required even if only the GSA retrofit were accomplished. Included in this amount are rent and telecommunications for swing space ($7.2 million); mail and shuttle services ($467,000); and moving costs ($575,000). The remainder includes $3.2 million for modual furniture; $4.7 million for ADP equipment, software and training; and cabling for the renovated VACO building ($387,000).

The GSA retrofit will replace major building systems including electrical, plumbing, and air conditioning; update fire and safety systems; and abate asbestos where necessary. VA wishes to use this opportunity to renovate the interiors of the building to improve space utilization.

In FY 1991, VA will spend $3.2 million ($13.4 million through FY 1994) for modular furniture as contrasted with $22 million being spent for basic realignment of space. No funds are requested for decorations.

VA COSTS BY COMPONENT AND PER EMPLOYEE

Organization	Amount	Estimated staff (FY 1991)
Secretary	$71,456	35
Veterans Health Services and Research Administration	1,149,426	563
National Cemetery System	338,907	166
Veteran Benefits Administration	1,002,431	491
General Counsel	232,744	114
Inspector General	265,409	130
AS/Acquisition & Facilities	1,220,883	598
AS/Information Resources Management	722,730	354
AS/Finance and Planning	453,237	222
AS/Human Resource and Administration	759,479	372
AS/Veterans Liaison	44,915	22
AS/Congressional & Public Affairs	116,372	57
Small and Disadvantaged Business Utilization	22,458	11
Board of Veterans Appeals	963,640	472
Board of Contract Appeals	28,583	14
Miscellaneous	114,330	56
Total	$7,507,000	3,677

Includes: Credit union, employee store, AFGE, GAO, and Association of Blindstand.

Chairman CRANSTON. Do you think any of that spending could be spread out a little bit longer?

Mr. **Principi**. Mr. Chairman, our utilities are breaking down. Our employees simply cannot be productive when our offices are 90 and 95 degrees in the summertime because the air-conditioning and the ventilation systems have gone down. We have a safety hazard. Employees are threatened by that safety hazard. This building and utilities simply need to be repaired. I don't think we can afford to stretch it out. Nothing in the planning calls for ostentatious offices, but rather functional, useful offices. The time is now. We are chasing good money after bad constantly trying to keep these systems up and they constantly break down and we are just wasting taxpayers' money.

I would urge the committee to allow us to go forward.

Chairman **Cranston**. Let me say that I'm not being antagonistic or challenging this, really. I think we're building a record now that justifies your decisions. I don't think the budget submission did that. That's one reason we are going into this at this point.

Mr. **Principi**. Yes, sir.

Chairman **Cranston**. If you would provide a written description for justification of any staff function that will receive greater space under the realignment, that would help.

Could the refurbishing be done without using modular systems, or do you think that is really a necessary approach?

Mr. **Principi**. I thought that was the most functional and cost effective, but we certainly could look into that, Mr. Chairman.

Chairman **Cranston**. I guess that's what drives the $16 million furnishing cost. What is the total furniture cost through fiscal year 1994? If you need to give that for the record, that would be fine.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

SPACE INCREASES IN RENOVATION PROJECT

Each organization will receive space based on the accepted GSA Government-wide space planning criteria of 125 square feet per personplus 22 percent for circulation. Overall, plans call for a reduction in the total amount of space that VA will require, after the renovation is complete. Space leasing costs are expected to be reduced by over $3 million per year.

As a result of the reorganization, approved by the Secretary of Veterans Affairs, certain organizational elements will require additional space after the renovation is complete. These organizations are: DAS for Congressional Affairs, DAS for Public Affairs, DAS for Facilities, DAS for Acquisition and Materiel Management, Board of Contract Appeals, and Board of Veterans Appeals.

The use of modular furniture, in conjunction with refurbishing the interior of the building, will allow VA to consolidate our headquarters operations, and save $3 million in annual rent payments. VA could not consolidate personnel into the headquarters building or realize the annual lease savings of $3 million without the use of modular furniture.

VA has decided to spread the costs for modular furniture over the duration of the Prospectus Project. Current planning calls for the headquarters building to be renovated in two phases; the first phase is scheduled for completion in December 1992. Modular furniture will be required at the completion of thisphase to enable staff to move from the unrenovated half of the building to the newly renovated area. The remaining modular furniture will be required at the end of the second phase, which is tentatively scheduled for October 1994.

Space saving furniture purchases for fiscal years 1991 through 1994 are as follows:

Fiscal year	(Dollars in millions)
1991	3.24
1992	3.33
1993	3.42
1994	3.495
Total	13.485

Mr. PRINCIPI. Also, the modular furniture will allow us to vacate certain buildings and have more of our employees at 810 Vermont Avenue, so we will save substantial leasing costs in some of the outlying buildings that we are currently utilizing.

Chairman CRANSTON. Is the total cost $16.6 million or $16.6 million times 4 for a 4-year program?

Mr. PRINCIPI. No, sir.

Mr. CATLETT. The $16.6 million in the general operating expenses budget is primarily for the rent while half of the employees in the building are out in rented space. Nearly $8 million, half of that, is there to meet that rental need that we have in the arrangement with GSA. We need to pay rent for those folks, as well, while we are out. Additionally, about $4 million of that is for the movement of our ADP facility out of the building during this renovation. So there is very little there, if any, that I know of, that is for equipment or for furniture for the future. That may be purchased at some point, and we'll definitely have a figure on what that estimate will be. But at least $12 million of those funds are for rental cost.

Chairman CRANSTON. So the furniture expenses would come later on in other years?

Mr. CATLETT. Yes, sir, and we'll provide that for the record.

Chairman CRANSTON. This question is for you, Ray. The Independent Budget contains, on page 29, assertions regarding the timeliness and quality of compensation claims processing and the size of the C&P claims backlog. You testified on February 21 before the House Veterans' Affairs Committee that the VA's pending workload is 381,000 and that this is a decline from approximately 420,000 in fiscal year 1989.

In DAV's written testimony, a detailed analysis of the figure contained in the Independent Budget is provided. DAV's analysis begins with the number of C&P claims pending as of September 30, 1988. The figure cited as of that date is 368,927 and is attributed to a recent VA communication to the House Committee on Veterans' Affairs.

Is the DAV September 1988, figure an accurate one?

Mr. AVENT. Mr. Chairman, rather than saying whether their number is accurate, I think I'd rather say that our number is accurate. I think the difference is the way we approach the counting process. The numbers that you have quoted are the numbers that we show in our system as of September 30, 1989.

Chairman CRANSTON. In September of 1988 was that an accurate figure?

Mr. AVENT. The 419,000?

Chairman CRANSTON. The DAV figure of 368,927. Was that accurate on September 30 of 1988?

Mr. AVENT. We show our number in September of 1988 to be 419,970, which is somewhat higher than the number they show.

Chairman CRANSTON. The next step in DAV's analysis is the addition to this number of pending cases of the sum of original claims, adjustments, and supplemental claims and ancillary claims upon which dispositions were not made during the 12 months prior to December 30 of 1989. This figure is 309,000 and is attributed to an operating performance report adjudication division, pending end-product workload, dated September 30, 1989. Is that figure of 309,000 an accurate figure for original claims, adjustments, and supplemental claims and ancillary claims as of September 30, 1989?

Mr. AVENT. As far as what we have pending, no. The correct number is 381,014. The number that you're quoting, the 309,000, I believe was incoming for that year. I think part of the discrepancy is the way we count. The numbers shown in the Independent Budget reflect the fact that several documents will come in pertaining to a veteran. After we put a claim under control, when a second document might come in which indicates that the claim is not an original claim but a reopened claim. At that point we cancel the second claim and continue the other. During the year we close 3.5 million end products.

I think that's part of the discrepancy. We are working with the service organizations to resolve the problem.

Chairman CRANSTON. Are you saying, in effect, that the DAV figures have some double accounting?

Mr. AVENT. Pardon me, sir?

Chairman CRANSTON. Are you saying, in effect, that the DAV figures got into some double accounting?

Mr. AVENT. Possibly so.

Chairman CRANSTON. Ray, your testimony on Wednesday before the House committee stated that "six of the eight categories of claims processing timeliness showed improvement between end-of-year performance for fiscal year 1988 and end-of-year performance for fiscal year 1989, and the other two categories have shown a recent trend of improvement based on the last 3 months of data."

VA's budget submission, on page 23–48, states that there are 15 standards of timeliness measurement, and that "virtually all of the key indicators have shown the continuing deterioration in timeliness."

These statements seem contradictory, and, taken with the assertions made in the Independent Budget, I am unclear what the actual size of the C&P backlog is, how many standards for timeliness exist, what the Department's current performance in terms of timeliness really is, and how VA has arrived at the most recent position that despite a much-reduced work force that has been persistently troubled by turnover, the backlog is decreasing and timeliness is improving.

Would you please explain briefly—and try to be brief—these apparent inconsistencies? And then please provide for the record a point-by-point analysis of the DAV's discussion on pages 8 through 12 of its testimony of how the figures contained in the Independent

Budget were calculated as contrasted with how your figures were calculated.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

DISCUSSION OF INDEPENDENT BUDGET CALCULATION

This is how we believe the Service Organizations arrived at their figure for the pending backlog for the start of FY 1990.

1. They took pending backlog from WIPP on 8/88 of 362,935.
2. They computed a pending workload from 3DK1 report as of 8/89 by subtracting the completed cases from the received cases. The twelve-month cumulative data is shown below:

Originals		
Received	811,046	
Completed	737,449	
Difference		73,597
Adjustments		
Received	1,952,304	
Completed	1,754,529	
Difference		197,775
Ancillary		
Received	474,989	
Completed	454,904	
Difference		20,085
Computed increase in C&P backlog		291,457

3. They computed the education backlog as:

End of FY 1988	28,418	
End of FY 1989	34,269	
Increase in education backlog		5,851
Total increase in backlog		297,308

4.

Increase in backlog	297,308
Plus C&P backlog end of FY 1988	362,935
Plus education backlog end of FY 1988	28,418
Plus 1 month of computed monthly backlog increase (297,308 divided by 12)	24,775
Computed backlog	713,436

5. We feel the difference between the VA figure and VSO figure is primarily the result of the VSO method of computing the backlog using the cases received figure from the 3KD1 report. The 3DK1 cases received figure may lead to duplicate counting of cases received because the field stations establish a pending issue control, indicating a case received, for each claim or issue received in the VA. The pending issue is often established without the claims folder. When the mail is associated with the claims folder, the pending issue may be canceled and a new issue established, thereby showing two claims received.

6. Our main concern is getting the claim under control as quickly as possible. We realize that some errors will be made, but feel the redeeming values of entering the claim into our tracking and control system as quickly as possible justify our procedure.

Mr. Avent. I will try to touch on all of those, Mr. Chairman, if I can in a quick manner.

First of all, the statement that we have shown improvement in the compensation and pension program from 1988 to 1989 is correct. In six out of the eight indicators we have shown a slight increase in performance from 1988 to 1989. We also have shown improvement in the other two categories in the first 3 months of fiscal year 1990.

Part of the credit for that improvement has to go back to our increased staffing level in the C&P program. If you go back to 1988, there were about 3,600 people in the adjudication divisions. We are now up to almost 3,750 people. So, in essence, those 150 or so bodies have increased the number of end products we have produced. We have definitely improved our quality and timeliness.

Chairman Cranston. Ray, if there is, indeed, double counting in DAV's computations based on your own figures, which is what they are based on, isn't there a way to develop a computer program that eliminates any such double counting?

Mr. Avent. We are working with the service organizations now to clarify the areas of inconsistency so that we might all work from the same data.

Chairman Cranston. If you could get together with them informally and just try to work out an understanding of whatever discrepancies exist, that would be helpful.

Mr. Avent. We have already begun doing that, Mr. Chairman.

Chairman Cranston. Good. Please let us know how that works out.

Mr. Avent. We will.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

> Informally a discussion has been held with Disabled American Veterans and that organization was furnished a copy of our white paper regarding the discrepancies in VA and DAV's pending backlog figures. Additionally a formal meeting is being arranged with DAV to discuss the methods of computation. The SVAC will be informed of the outcome of the discussions.

Chairman Cranston. Ray, although the President's fiscal year 1991 budget significantly increases VBA's ADP support of both the 12-point modernization plan and the current system, VBA's response to the committee's informal questions indicates that nine requested ADP initiatives were denied in the OMB passback. What impact will the noninclusion of these initiatives have on the pace and quality of VBA's modernization plan and its efforts to provide timely service?

Mr. Avent. Mr. Chairman, the items that were not included in the 1991 budget were mostly current system initiatives. Our projection is it will not halt the modernization plan at all. We are still on schedule to make our purchases and award contracts in 1993.

Chairman Cranston. Does that really mean that these were frills and not necessities?

Mr. Avent. They were not frills, Mr. Chairman. To give you one example, we are working on a loan processing system ADP initiative. We are now involved in phase one of that loan guaranty process system. The 1991 budget did not include phase two. That will not halt us moving forward. No, these were not frills, but priorities were established.

Chairman CRANSTON. Thank you.

Ed, I wrote a letter to you on September 27, 1989, regarding the status of the final regulations for using Medicare's prospective payment system for VA payments to private hospitals. This issue has been pending in VA for several years now, and it is costing VA money each day the regulations are not issued.

Can you please look into the status of this matter and get back to me as soon as possible?

Secretary DERWINSKI. I think Tony——

Mr. PRINCIPI. It certainly has been a very discouraging, long process. I think we are finally there.

Chairman CRANSTON. OK. Ed, on Wednesday I sent you another letter concerning the Veterans Advisory Committee on Environmental Hazards. In the letter I sate my concern that the advisory committee should be meeting right now to consider the very important new study released by the National Academy of Sciences on the health effects of exposure to low levels of ionizing radiation and that the committee is inappropriately funded from the MAMOE account rather than from GOE.

Don't you agree that the group's statutory responsibilities are related primarily to compensation and not to medical care?

Secretary DERWINSKI. I have not seen that letter yet. I will get you the response as soon as I can. And I'll also ask to be updated on the issue.

Chairman CRANSTON. Fine. If you could respond to my letter by March 5, I'd appreciate it.

Ed, I'm going to give you a list of several outstanding letters to VA to which I haven't received a full reply yet in writing. If you could please look into the status of each and let me know by Wednesday when they will be responded to I'd appreciate it.

Could you give us the status of your modification of VA's underwriting regulations—home loan underwriting?

Mr. PRINCIPI. Can you handle that?

Mr. AVENT. They are currently being reviewed and should be coming forward very soon.

Chairman CRANSTON. They've been under review months and months—for quite a long time now, haven't they? If you can, expedite that.

Do you have any kind of a target date?

Mr. AVENT. We will provide that information for the record.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

> The proposed underwriting regulations were published in the Federal Register on Feburary 12, 1990 (55 FR 4869). The public comment period ends March 14, 1990. We expect final regulations to be published in July, 1990.

Chairman CRANSTON. Ed, the written testimony of the Manufactured Housing Institute presents several alternatives to your proposal to eliminate completely the VA manufactured home loan program. Would you please reevaluate your proposal for total elimination of the program in light of these suggestions and provide a written statement of VA's views on each of the suggestions made in their testimony?

Secretary DERWINSKI. We'll do that.

Chairman CRANSTON. Thank you.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The Manufactured Housing Institute recommended seven changes in the VA manufactured home loan program.

The first recommendation was that VA review requirements on income levels and debt-to-income ratios and vigorously apply sanctions to program participants who fail to follow the guidelines. The recently-published proposed rules on credit underwriting referenced in Question 1 contain revised guidelines on when lenders may approve loans based on residual income and debt to income ratio. Under these regulations the lender would be required to certify that the loan conforms to VA underwriting standards. Civil penalties are provided for a false certification.

The second recommendation is that VA centralize manufactured home loan processing at Central Office or three regional offices. If the Congress does not accept our recommendation to terminiate the manufactured home loan program, we will consider centralized processing of manfactured home loans.

The third recommendation is for a manufactured home loan handbook. Presently program participants are provided with administrative releases which fully describe the requirements and procedures for processing manufactured home loans. However, if Congress does not accept our recommendation to eliminate the manufactured home loan program, we will consider developing a handbook for manufactured home loans.

The fourth recommendation is to amend the VA regulations to include incentives to facilitate the resale of repossessed manufactured homes at their original sites. This recommendation did not elaborate on what sort of incentives may be available. VA would not be able to require owners of manufactured home rental parks to allow vacant homes to remain on site. We believe this recommendation points up the fact that manufactured homes permanently attached to the land are preferable to manufactured homes in rental parks. Our proposal to eliminate manufactured home loans does not call for elimination of loans for manufactured homes permanently attached to the land and treated as real estate under State law.

The fifth recommendation is to amend VA regulations to allow inclusion in the loan of only those items which will make the home a safe and sanitary residence; i.e., to disallow items such as furniture and other accessories. We would support this recommendation if Congress does not accept our proposal to terminate the manufactured home loan program.

The sixth recommendation is to amend eligibility requirements for VA home loan guaranty benefits to include National Guard members and reservists. We believe it may be appropriate to extend eligibility to these veterans to expand the base of veterans eligible for home loans and thereby reduce losses because of increased funding fee collections. However, any such proposal must make clear distinctions as to the extent of the benefit provided between reservists and National Guard members on the one hand and active duty veterans on the other hand.

The seventh recommendation is to urge DOD to cooperate with VA when transferring personnel with outstanding VA-guaranteed loans. Base housing officers would notify VA and the lender as soon as it is known that these personnel are to be transferred. VA supports homeownership counseling by lenders and base housing officers. However, our offices report varying degrees of concern among base housing officers on assisting veterans with VA home loans. This is an area which could be further explored.

Chairman CRANSTON. Regarding the sale of VA vendee loans, it is unclear what type of sales you plan to conduct in fiscal year 1991. The most recent sale on January 25 used the so-called "partial recourse" structure. Do you plan to use the same structure for all sales in fiscal year 1991?

Secretary DERWINSKI. We're looking at that now and discussing the issue of the vendee loan sales with OMB to ensure that we maximize our return. I'll respond in writing.

Chairman CRANSTON. If you could, please respond in about 15 days.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

We are still evaluating our alternatives. A decision has not been made with respect to loan sale structures for the remaineder of FY 1990.

Chairman CRANSTON. I want to now turn to some questions on the National Cemetery System. Jo Ann, I'll turn to you at this point.

First, I want to congratulate you on expediting the purchase of headstones or markers for those who were killed in Panama. In moments of tragedy and personal loss, it is exactly that type of sensitivity that shows the Government's commitment to and respect for its servicemen and women.

Also, I want to comment on the letter you sent to the field describing your difficult decisions to cut back in several areas this year in light of budgetary restraints. I found your choices of priorities and explanations in that letter very thoughtful and very responsive, and I thank you for that, too.

With regard to the equipment backlog and maintenance funding shortfall that the national cemetery system presently faces, I am very concerned that the effects of the backlog and shortfalls, in addition to causing immediate services to be curtailed and cemeteries becoming dry and inadequately maintained, may result in significantly higher long-term costs to remedy the deterioration of the system's infrastructure.

I understand that repairs to roads and buildings are being done only when absolutely necessary—even then, not completely. I also understand that the current equipment backlog is $6.3 million and that the cost of replacing the equipment that is no longer useful this year is over $3 million.

The fiscal year 1991 budget request includes $2.2 million for replacement equipment, but I understand that amount would be insufficient to cover the cost of replacement equipment for that year, so that you will end up with a $7 million backlog at the end of fiscal year 1991 under the budget request. Is that an accurate appraisal.

Mrs. WEBB. The $7 million is an estimate, but that is very close to the actual sum. Each year $2.5 million worth of equipment becomes due for replacement. However, there are efforts in the field to move equipment around, to make repairs on site so that we are operational, and maintain our interment capability.

Chairman CRANSTON. Do you agree that the equipment backlog, if not remedied, will likely result in additional future costs in maintenance and repair projects that have been either postponed or addressed with a quick fix?

Mrs. WEBB. Yes, I believe that is a fair estimation. Yes, sir.

Chairman CRANSTON. Do you have any studies or papers that quantify these costs?

Mrs. WEBB. We have an in-house report that examines the age of our entire equipment inventory.

Chairman CRANSTON. Could you share that with us?

Mrs. WEBB. I certainly will.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

SUMMARY OF EQUIPMENT STATUS

Type of equipment	Number of items	Number extended [1]	Percent extended	Average year extended
Interment	1,544	580	37.5	[2] 6.35
Ground and graves maintenance	6,561	1,095	23.1	4.8
Total NCS System	8,105	2,095	25.8	5.23

[1] Extended means kept in service beyond the number of years of useful service for that piece of equipment.

[2] Burial (interment) equipment is expected to last 10 years while 37.5 percent of our equipment has been in service more than 16 years.

Chairman Cranston. What funding level in fiscal year 1991 would allow the national cemetery system to replace necessary equipment and maintain all cemeteries at high standards of maintenance and dignity?

Mrs. Webb. I don't have a figure for you, but I——

Chairman Cranston. If you would, please provide that for the record.

Mrs. Webb. Yes, I will provide one for you.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Funding Requirement for 1991

A funding level of $69 million would enable NCS to restore and maintain the expected standards of maintenance and appearance and conduct burial operations with fewer costly emergency breakdowns at our national cemeteries. The $69 million would be an increase of $15 million over the 1991 President's Budget. The increase would be primarily applied to eliminating the replacement equipment backlog ($7 million) and supporting 100 additional field FTEE for grounds and graves maintenance ($3 million). The $5 million balance would fund previously deferred maintenance and repair projects, acquisition of additional equipment necessary to meet increased workloads, and the supplies and materials such as seed, fertilizers, repair parts, purchased utilities such as electricity and water necessary to operate and maintain a national cemetery.

Chairman Cranston. Does the fiscal year 1991 budget provide sufficient funds to allow for meeting workload demands and restoring the cutbacks in areas like watering?

Mrs. Webb. The workload, yes. The water issue is complicated and it is an issue that the Cemetery System is examing. The approach we are taking is environmental, in an effort to examine what we have done in the past and what we need to do in the future.

Chairman Cranston. As I am sure you are aware, press reports have recently begun to detail the adverse effects of NCS watering restrictions on the Fort Rosecrans National Cemetery near San Diego. I understand that much of the once-green landscape there has been replaced by a dull brown, and that if the restrictions continue much longer all the grass will be lost. Since the cemetery buys its water from the nearby San Diego Navy Base, it is especially frustrating to see this national cemetery deteriorate for want of water that is available and owned by the Federal Government itself.

Ed, turning to you, given the urgent need for the water, couldn't some novel, innovative agreement be worked out with the Navy to get access to that water?

Mr. PRINCIPI. That's something we should explore. Mr. Chairman, you know as well as I how serious things are in California with regard to water. We are looking at innovative approaches to address that problem.

Chairman CRANSTON. Tony, given your connection with San Diego and the Navy, you could be a better man to undertake that.

Mr. PRINCIPI. I'd be happy to.

Secretary DERWINSKI. Senator, I can't help but comment that with your problem of the tragedy of the earthquake and now this water problem you referred to in southern California, I would not be surprised if a lot of Californians didn't start moving back to Illinois. [Laughter.]

Chairman CRANSTON. No chance.

Ed, I'm almost to the end of this part of our hearing. I know, both from conversations that we have had and from your interim response on January 9 to a letter from Don Edwards and me about a case of alleged retaliation against a VA employee who testified before a congressional committee, that you share my view—we have discussed this—that retaliation against any VA employee who testifies truthfully before Congress or in court or who otherwise provides truthful information to the Congress is a very serious matter. Do you have any comment on that?

Secretary DERWINSKI. Yes. I agree with your concern. Correct me if I'm wrong, but I believe the particular case you refer to had to do with an issue 2 or 3 years ago in which one of our employees was legitimately, in my opinion after a review of the case, acting in what we in Government call a "whistleblower" capacity. And, quite frankly, from my years in the House as a member of the Post Office Civil Service Committee, I think the support of and cooperation with and protection of people who, in the interest of good Government, have to use that procedure is something I would support. If I may also state, I do have a copy of your question and comments. As far as I am concerned, we want all of our employees to be open. We don't muzzle anyone. We don't practice censorship. In fact, we have our own in-house system of encouraging comments directly to the Secretary in order to see what improvements we can make in the system.

Philosophically I don't think we have a problem. Or, for that matter, on a practical basis, we have no problem in this area.

Chairman CRANSTON. Good. That's a very forthcoming response. I thank you very much for it.

Against that background I want to share with you reports that I have received that there is a good deal of apprehension today among some VA field personnel that anyone who testifies before Congress or otherwise assists the Congress is jeopardizing his or her career or financial security. Sometimes these concerns derive from an unreliable or faulty rumor mill. I recognize that. But the anxieties they produce are no less real.

Just so the record can be clear, Ed, I want to ask you the following question: Is it your policy that under no circumstances would an individual VA employee providing truthful information to a congressional committee or Member in response to a request for such information from the committee or Member be taken into account in any personnel or pay action affecting such an employee?

Secretary **Derwinski**. First, your thoughtful and considerate staff FAXed over this question and your commentary to us yesterday. My first reaction, I must tell you honestly, I was temporarily upset because I first interpreted the question to be something of a personal and official put-down. But let me state, first, that we have no problem with any of our employees in their contacts with any House or Senate office or committee. In fact, as an old House Member it would be contrary to my own experience to try to have any interference with logical communications between any of our employees and Members of Congress—especially those looking after their State and local interests.

The only disciplinary actions that I have been involved in in my first year as Secretary is where GAO or IG reports show any individual to be involved in especially poor judgment or poor leadership.

Our interest is the veteran, and the only rule we set down for judging the performance of people in the field or in the Central Office, frankly, is how well they are serving our veterans—the yardstick we apply to ourselves.

The one thing, however, I have continually done in every meeting, especially with our medical center directors, is lecture them on what seems to have been, I think, a runaway practice in the VA of too many individual medical center directors contacting their local House Members or Senators from their State pleading a case specifically for their own entity. As a result, we either get amendments or we get decisions forced on us that skewer the entire system.

Since we want all our veterans all over the country to have equally good access to equally good medical care, we'd like to have them flow through the proper procedure through the regional offices, through VHSRA, up to the chief medical officer, and we would make the rational decisions.

The only thing I have lectured them on is this tendency to occasionally run the end. As an old Congressman I understand the trick and the game. That's the only thing I object to.

But as far as the rumors, the VA rumors run rampant. I must say, for the most part, they are reasonably accurate, although quite imaginative. We are not bothered by them, and we encourage our employees, frankly, to give us constructive criticism. I will take no action of negative nature merely because someone was negative in their commentary to me or to anyone else.

Chairman **Cranston**. I thank you for that. Let me say that we FAXed that to you yesterday so you'd have time to think about your response and so if you got upset, you'd have time to think about it and not be upset this morning.

Secretary **Derwinski**. I cooled off a little. I'm a little like Tony. I have an Italian temper. It flares and then I calm down and all is well.

Chairman **Cranston**. In effect, you do affirm the answer to my question.

Secretary **Derwinski**. Yes. And I also want you to know that I personally support whistleblowers, per se. I have my own private post office box for whistleblowing within the VA system.

Chairman **Cranston**. Great. We were referring less to whistleblowers than to requests from us for information.

I think that's a very fine answer. I think it might be a good idea for you to communicate that feeling about all of this to people out in the field.

I understand, Ed, that you did your best in seeking answers to my prehearing questions cleared by OMB. However, there are still many sitting over at OMB that we need to have in building our budget recommendations. So please keep after OMB and do all you can to get answers back to us as early next week as you can.

Also, Ed, we do have some further written questions for you. Some of them we need answers to immediately for our budget markup. We'll indicate those with an asterisk and get them to you this afternoon, the rest on Monday. Could you please do everything you can to get those answers to us by the end of next week?

Secretary **Derwinski**. We'll do the best we can.

Chairman **Cranston**. I'm referring to those that will have an asterisk with them.

I want to note that clean air negotiations are going to keep Senator Mitchell from attending during your appearance. His statement on the Togus consolidation waiver legislation will be entered into the record. He will be submitting written questions for himself and Senator Cohen for response by the Secretary.

[The prepared statement of Senator Mitchell appears on p. 148.]

Chairman **Cranston**. We also have a statement from Senator Matsunaga that will appear in the record.

He extends his apologies to the Secretary, other administration witnesses, and the service organization representatives for not being able to attend the hearing. Despite his absence, he will continue to monitor budget issues closely.

[The prepared statement of Senator Matsunaga appears on p. 149.]

Chairman **Cranston**. I now welcome Senator Rockefeller to this hearing.

Jay, at this point if you have any comments or questions or whatever they would be most welcome.

OPENING STATEMENT OF SENATOR ROCKEFELLER

Senator **Rockefeller**. Thank you very much, Mr. Chairman.

Good morning, Mr. Secretary. I am delighted to see you. I want to congratulate you personally on the sharp uptick in the 1991 budget for the Veterans' Administration. I don't know how an 8.4 percent increase comes about, but I've just got to believe that you are largely responsible for that.

Secretary **Derwinski**. The secret is I sent Mr. Darman an extra large Christmas card.

Senator **Rockefeller**. Well, it is a secret that others haven't found out about. You need to be congratulated for that, and I'm very sincere because we have basically been going the other way over recent years.

Although, we still have that immediate supplemental need for $252 million.

I have a couple of questions I would like to ask. If they appear, in any way, to be parochial, you'll know that it is very untypical of me.

The first one I wrote a letter to you in fact, recently. It relates to my understanding, at least, that the Huntington Veterans Medical Center was scheduled to begin "advanced planning" of what we feel is a badly-needed research addition next year, i.e. 1991, and then begin construction of that research addition by the year 1994. I have been told that the VA has decided to delay planning by 1 year and actual construction wouldn't begin until 1995.

Using the VA's own criteria on space allocation for research and development, demonstrates that the Huntington VA Medical Center is seriously short on adequate working space. Current standards recommend 22.6 thousand square feet for a research program the size of the Huntington VA Medical Center. At the present time we are confined to 9,583 square feet.

I assume that you can't respond to this question on the spot and, as I said, I have written you about this very recently. I would very much appreciate knowing why the delay.

Secretary **Derwinski**. I will answer you as soon as I can.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

CONSTRUCTION—VAMC HUNTINGTON, WV

The VA Medical Center, Huntington, WV, has identified the need for construction of research facilities to supplement those facilities which currently exist at the medical center. This project, which has an estimated cost of $11.4 million, has not been included in the Department's Medical Facility Development Plan prior to 1995 based upon system-wide priorities and projected resources. The research program at this medical center has not grown as anticipated previously. The needs for research facilities at Huntington will be monitored and any needed construction will be considered as future planning decisions are made.

Secretary **Derwinski**. But may I just take a moment to tell you one thing which we hope will be positive. I would direct this to all the staff members, as well, representing other Senators.

We are trying to institute a system of more rapidly and more fully and precisely answering mail from Members of Congress. We also are trying to establish a system whereby our responses will be in the English language, not bureaucratic gobbledygook. It is something we are working at and something that has my personal attention. We will stay on top of your personal letter but, in addition, our entire thrust is to have a more effective, precise, and speedier communication with all Members of Congress.

Senator **Rockefeller**. I don't really think that's much of a problem here. I wrote the letter on February 15, which is, in the ways of Washington, pretty recently. I don't think you have to apologize for that.

The next question has to do with manufactured housing. That is of concern to me. I know that you have a high default rate on manufactured home loan programs, but aren't there other ways of addressing this issue other than eliminating a another very important veterans' program? Aren't there ways, in effect, to strengthen the manufactured home loan program and, at the same time, address default rates? Again, I don't expect an answer right now. But I think it is a good program. Manufactured homes have improved enormously in their quality in recent times. Obviously they have become much more affordable for some people. In States like mine, homes are tough to come by. I would ask if perhaps you could respond in terms of your philosophy about that.

Secretary **Derwinski**. We will. More than that, Senator, you have been especially thoughtful and objective discussing problems with us. We have also appreciated the fact that we have had access to you. Mr. Principi and I would like to come up and visit with you specifically on that entire issue. We will be in touch with your appointments secretary to see if we can get on your schedule soon.

Senator **Rockefeller**. I'll look forward to that.

Mr. Secretary, I'm spending a lot of my times these days on something called the Pepper Commission, which is six Senators and six Congressmen, the so-called "health players" in the Senate and the House, and three members appointed by the previous administration. Our mission, in a sense, is to point the way boldly toward universal access to health care so that the 37 million Americans who don't have health insurance at this point can, and also issue recommendations for long-term care.

Long-term care is not just for people 65 and older. Forty percent of long-term care needs in this country are for people who are under 65 years: children with spina bifida, head injuries from autobile accidents; a 45-year-old with multiple sclerosis who is too well-off for Medicaid and years and years from Medicare. It is an enormous, enormous need.

It is an even more enormous need among veterans because veterans are aging at a faster rate than the U.S. population, as a whole—in fact, three times faster than the national population as a whole, which is an unbelievable statistic.

Today there are 5.7 million veterans over 65 years of age. In 20 years it is going to be 9 million.

I am wondering how you look at our budget situation and how it is that the VA should gear up in terms of the long-term care needs that are so dramatically growing for the veterans of this country.

Secretary **Derwinski**. I have been well instructed by Dr. Gronvall and our other experts on that problem, that great challenge we have of the aging veteran. As far as I am concerned, that is our greatest area of responsibility.

All of our veterans, even the youngest one on our rolls, ages day by day. Right at the moment we have the World War II veterans who are the group we must contend with as the average age, I believe, is 68 for the World War II veteran. There are 11 million of them.

This is one of the major issues we are addressing in our commission that I am establishing to take a look at long-term services that veterans will get from the VA. I think any look at those statistics which you cite directs one to the fact that we must, with much greater emphasis, be adjusting our services, our skills, new facilities, and upgrading facilities to serve the needs of the chronic ailments of older veterans. We are very sensitive to it, and will be addressing that as a top priority measure.

Senator **Rockefeller**. Mr. Chairman, that's all the questions I have.

I just again want to reiterate to Mr. Derwinski the very pleasant surprise in terms of the aggregate numbers with respect to the budget. Obviously, in PTSD and some other areas I think there are some deficiencies, but I think you should be congratulated, sir, for having the administration come forward with that kind of budget.

Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you very much, Jay.

Ed, you and Tony and John and Ray and Jo Ann have been very, very helpful, and I appreciate it a great, great deal. I appreciate your patience and perseverance. I thank you for your very forthcoming responses and your testimony this morning. Thank you very, very much.

Secretary **Derwinski**. Thank you, Senator.

Chairman **Cranston**. I would now like to call to the table and welcome Thomas E. Collins, who is Assistant Secretary of Labor for Veterans' Employment and Training. This will be his first testimony since his Senate confirmation.

Tom, I look forward to your testimony on the fiscal year 1991 Department of Labor budget regarding veterans' employment and training programs. Please do your best to summarize it in 5 minutes. The whole statement will, of course, appear in the record.

I understand you are accompanied by Richard Larson, Executive Assistant, Veterans' Employment and Training Service.

We welcome you both.

STATEMENT OF HON. THOMAS E. COLLINS III, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR, ACCOMPANIED BY RICHARD LARSON, EXECUTIVE ASSISTANT, VETERANS' EMPLOYMENT AND TRAINING SERVICE

Mr. **Collins**. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to present to you the fiscal year 1991 Department of Labor budget as it pertains to the Veterans Employment and Training programs.

I am accompanied today by Richard Larson, my agency's manager in charge of budget preparation. Also in the audience is John V. Meyers, the Deputy Assistant Secretary.

You will find, after reading our request, that the disabled veterans outreach program and the local veterans employment representatives program contain slight increases; however, these will fund less than the number of positions mandated by the legislative formula.

Also, in fiscal year 1991 our request for the National Veterans' Training Institute at the amount of $829,000 does not meet the level required by the contract presently in force.

I am pleased, however, to report that our request for the full-time equivalent positions for the agency will be sufficient for us to carry out our established mission.

At this time, rather than go through the rather lengthy prepared statement, I would like to submit the statement in writing for the committee's consideration.

Chairman **Cranston**. Fine. It will appear in the record in full, of course, following your oral presentation.

Mr. **Collins**. Again, I appreciate the opportunity to appear before you for the first time as Assistant Secretary for Veterans' Employment and Training, and I will be happy to address any questions.

[The prepared statement of Mr. Collins appears on p. 157.]

Chairman **Cranston**. Thank you very much. That's very courteous and thoughtful of you, given our tremendous workload this morning and the great deal of ground we have to try to cover.

Let me start right in with the questions.

Prehearing question 4 asked for an explanation as to why the President's budget does not comply with the statutory requirements in section 2003(A) and 4 of title 38 for DVOP and LVER funding. In response, you stated, "The requested level of DVOP and LVER positions is consistent with the larger national objective of budgetary constraints."

That obviously is not a very adequate response on the real issues involved. I don't believe that any executive branch official has the authority to disregard the will of the Congress and determine that that kind of objective excuses a knowing violation of a Federal statute. I'm sure that written response did not reflect your personal views.

In regard to the mandatory funding levels for DVOPs and LVERs at your confirmation hearing, you stated: "At this time and always in the future, realizing that the DVOPs and LVERs are the work of our organization, they deliver the services, I will always advocate fully funding, as mandated, these programs."

Tom, I hope you will continue to fight for the mandated levels. I promise that I will be doing all I can in the Congress to get that level appropriated. I regret that the administration's official opposition is going to make it harder to achieve.

As to DTAP and TAP, as you know, the DAV has done much ground-breaking work in the transition area. Would you please meet with DAV officials and those of any other interested service organization specifically to discuss their concerns about the direction of your transition program? Would you be able to do that?

Mr. **Collins**. Yes, sir. We have, of course, in the 1991 request, $225,000 which will be focused on the job information system—the computer system. Of course, it is a pilot project and it will still be a pilot project due for a report at the end of 1991 to the Congress.

The other costs, which are very difficult to isolate or determine, will be done through existing resources. These costs—and it is very difficult, since we are right now in the planning stages of the first pilots—will be travel of both Federal and State agency personnel, and the training which will be done as part of our National Veterans' Training Institute.

So, we are still in the planning stages for the initial pilots. I am very optimistic about having successful pilots. We are approaching the pilots, as they should be, on a test basis. We will be working our problems. We are not setting out to prove that we have any magic, but we do realize that there is a great need and perhaps will be a continuing need for proper, orderly transition assistance of our present-day and future military service personnel back into the civilian job market. So I am very optimistic about that. That has the utmost of my attention.

Chairman **Cranston**. And will you meet with DAV and other people to go over their concerns?

Mr. **Collins**. Yes, Mr. Chairman, at any time. In fact, I have recently had meetings with various organizations, and I'm happy to at any time.

We have, in fact, a very good public outreach effort underway which falls upon me and my deputy and other key staff people to carry out. So we are very enthusiastic about the TAP and DTAP pilot program, and we are anxious to tell everyone who is interested what we are doing to encourage their support.

Chairman **Cranston**. Good. Thank you.

It is reported on page 19 of the budget documents that, due to a focus of efforts on improving veterans' employment rights, the average case processing time decreased significantly in fiscal year 1989. With the DVOP and LVER staffing cuts resulting from sequestration in fiscal year 1990 and proposed by the President for 1991, what will be the impact on the average case processing time for these 2 years?

Mr. **Collins**. Referring to the VRR—veterans reemployment rights--case processing, and the impact of the DVOP LVER positions will be very indirect. Most of our case processing is done by our Federal staff—very typically, an assistant State director who is normally assigned to process our VRR cases.

Chairman **Cranston**. Tom, you are aware of my strong support for the National Veterans' Training Institute. I authorized the legislation which, in May of 1988, established the Institute as a statutory entity, and I continue to be a strong supporter of the Institute and its mission today.

Under the reduced funding level for the Training Institute with no supplementation, how many individuals in what categories will not be trained in fiscal year 1991 but would have been if you were to train the same number as in fiscal year 1990?

Mr. **Collins**. It will be, in terms of trainees, approximately 1,500, in the sense that the current funding level equates to approximately 500 trainees, and we have estimated the demand for 1991 to be approximately 2,000.

Chairman **Cranston**. What was the training level in your contract advertisement?

Mr. **Collins**. The contract is the 2,000 number.

Chairman **Cranston**. On what basis and under what circumstances would the contract be canceled and readvertised for the lower funding level, as you suggested as an option on page 22 of your budget documents?

Mr. **Collins**. Yes, sir. That is a possible option. It was written, I believe, in that document as the last appearing option, and that is for a reason. I frankly do not anticipate ever having to exercise that option, using the others first. I believe the first option—and I'm not referring to the written text at the moment—was to supplement perhaps a contract with other outside participants. And, of course, the contract is a contract, and I am committed and appreciate your support for our National Veterans Training Institute. For legal, as well as other obligations I intend to see that the National

Veterans' Training Institute does operate according to the contract, which means I will perhaps have to divert funds from other sources.

Chairman CRANSTON. Thank you.

What is the status of your efforts to train all DVOPs and LVERs at the Institute?

Mr. COLLINS. In general numbers, we completed the core training for all of our DVOPs and LVERs in fiscal year 1989. You may note in some of the data that is presented, that was our peak year of attendance. The agency is taking pride in having completed that initial training, and by way of evaluation we have observed the results thereof.

Our measurement of accomplishing our standards for hiring veterans or getting veterans better employment positions have increased almost across the board, and we attribute much of that improvement and that success to having good training at the Training Institute.

So we peaked in 1989 having accomplished the mission of giving the basic training to all of our State field staff personnel.

Chairman CRANSTON. Are there more DVOP and LVER new hires and TAP staff anticipated in fiscal year 1991 and late 1990 than the 500 training slots that you have requested institute funding for?

Mr. COLLINS. Sir, that is difficult to predict. We do have an ongoing problem—which I'm happy to report is improving—and that is turnover, especially in the DVOP positions. We are seeing signs of improvement. The excellent training being provided is one of the reasons I believe that turnover is improving.

However, turnover in those positions within the States continues to be high. It is very difficult to predict what the turnover will be. We do deal in the lapse rate which is simply a buzz word for the turnover. It tends to be extremely high.

I think the 500 would perhaps cover new hires, but, of course, we had estimated the demand to be 2,000. This goes far beyond the basic core training that a newly-hired DVOP would attend.

We are currently operating five courses at the institute and are developing other courses, one of which is the transition assistance course. But we have the veterans benefit course, we have a specialized course in veterans reemployment rights, VRR, to give you an example. So the demand of 2,000 is realistic. The 500 could perhaps—and we have not planned it in these terms—take care of new hires and training.

Chairman CRANSTON. This is my last question. The President's budget includes $200,000 for the replacement of outdated personal computers. How much did the Department include in its initial request to OMB for this purpose, and for what specific activity?

Mr. COLLINS. Yes, sir. With the assistance of Mr. Larson, who is our budget manager. That $200,000 is part of an ongoing plan to modernize and bring up to departmental standards our computer equipment. The $200,000 was our original request.

Chairman CRANSTON. Tom, I'll have some posthearing questions for you, and I'd appreciate your doing your best to respond by the end of next week.

Mr. COLLINS. Yes, sir. Thank you.

Chairman Cranston. Thank you very much.

Senator Rockefeller.

Senator Rockefeller. Mr. Chairman, I will try to be very brief. I can see the frown on your brow.

Chairman Cranston. Not at all. Go ahead.

Senator Rockefeller. You have said that veterans' unemployment has declined since 1987, and obviously that's good news. You said there has been significant improvement in services both for DVOP and LVER. And you also attribute that, in talking to Senator Cranston, to the training received at the National Veterans' Training Institute. Then there is a reduction in funding of over $800,000, which isn't a lot unless you realize that the entire budget is $2.1 million, so that's a very big drop. I don't understand it. If it is working, why the decision to cut that much money?

Mr. Collins. Yes, sir. The answer is that we have a contract that we will be obligated to fund, so we will conduct the training that we need. We, of course, will be looking for alternatives. We could go back to the options which we discussed earlier of having alternative funding and other cost-saving measures that perhaps we can ensure.

A choice I had to make with a fixed amount of resources was between the training and the overall operation of the agency. I will meet the contract, as I indicated earlier—a legal and a management criteria. It will severely hurt other programs of a discretionary nature.

Senator Rockefeller. Are you saying, then, that you are so confident of the alternative prospective arrangements for training that you can make the cut at this point because you assume to fill in from other areas? That's more than one-third of the budget.

Mr. Collins. We are, of course, committed legally to the NVTI, so we will have to divert money from other discretionary sources to meet that contract and to meet that training demand; however, that would severely hamper the other operations of the agency—our other outreach programs, special projects out into the community and in the veterans community that would severely hurt the long-range operation of the agency. Training is important.

Senator Rockefeller. One of the things that Chairman Cranston has heard me talk about many, many times is unemployment. In West Virginia it is very high. We have lost 200,000 people, in the last 5 years, who have gone elsewhere because they can't find work. LVER is obviously a critically important program for us in a State where veterans are enormously prevalent.

The rate of placement from LVER has increased. It has increased to 17 percent from 14 percent, which is a 3 percent increase. That strikes me, regardless of the increase, as a very low number. Is that what happens generally in training programs throughout this country? What is going on in LVER? How does that compare with other training programs, generally? Seventeen percent of those in it are somehow placed. Also, what is the situation in West Virginia?

I would be glad to have whatever answer you have, but I would also very much like for the West Virginia part of it to get a response later on.

Mr. COLLINS. Yes, sir. I appreciate your question. I will need to followup in writing later on with specific information about West Virginia, and perhaps to research the overall employment service situation to see how we compare.

In general terms, I can tell you now that our DVOP/LVER statistics and performance rate are good. They are better than other types of employment services, and we're proud of it. That's why I like to brag about it.

Senator ROCKEFELLER. Do you mean better than others around the country?

Mr. COLLINS. At the risk of certainly not putting anyone else or any other type of organization down, I can say that I am proud of our DVOPs and LVERs.

Preceding the end result figures, of course, we increased from 70 percent to 86 percent of the veterans' applicants that we provided some service to. So we provided some service. Hopefully many times that service resulted in that veteran getting a job. Of the veterans that we had contact with, we provided 86 percent with some service.

The way we measure our performance is where the increase to 18 percent came in. We can actually take direct credit for having helped those veterans find a job.

So our people are well trained and do an excellent job.

Senator ROCKEFELLER. I appreciate that. And, as I indicated, I'd appreciate an answer on the West Virginia part of it: how you see that program; how it is faring in comparison to the national program; and how you evaluate it.

Thank you, sir.

Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you, Jay, very much.

Thank you very much for your testimony. We look forward to working with you.

Mr. COLLINS. Thank you very much, Mr. Chairman.

Chairman CRANSTON. Thank you.

The next panel will discuss the fiscal year 1991 budget submission for the U.S. Court of Veterans Appeals, as well as the court's funding for the current fiscal year and its plans to relocate to more permanent quarters.

I welcome back Frank Q. Nebeker, Chief Judge of the court, and Jim Caldwell, Chief Deputy Clerk of the court. Thank you both for being here this morning.

Frank, while I have a moment I wanted to acknowledge the outstanding work you have done the last several months in getting this new court off the ground. I know it has been quite an undertaking. The enthusiasm you have displayed has been most welcome, as has been your exhaustive attention to all details pertaining to the court.

I also want to acknowledge not only your excellent cooperation, but that of Melanie Dorsey with the committee on a wide range of matters of mutual concern as the court is getting underway.

It has been my pleasure, Frank, to try to be as helpful as possible in securing adequate funding for the court and in working with you on technical corrections or clarifications of the legislation establishing the court, and otherwise helping to ensure successful launching of this truly historic venture.

Now, if you would like to make a statement, please try to do it in not more than 5 minutes. The floor is yours.

Judge NEBEKER. I shall do it in less.

STATEMENT OF HON. FRANK Q. NEBEKER, CHIEF JUDGE, U.S. COURT OF VETERANS APPEALS, ACCOMPANIED BY MELANIE G. DORSEY, EXECUTIVE OFFICER AND CLERK OF THE COURT

Judge NEBEKER. Thank you kindly, Mr. Chairman, for your helpful and kind comments in your written statement and that which you have said this morning.

I feel a bit fiscally insignificant in light of the billions of dollars you have been talking about around here this morning, but, nonetheless, I recognize the intended importance of judicial review, and that is my challenge in the next number of years.

As you observed, the court budget request is made up substantially of estimates, and that is, indeed, true for the next fiscal year. That is why we ask that section 509, the earmarking of funds for personnel, etc., not be made to apply again for fiscal year 1991.

Let me compare the budget of our court with the only two comparable situations that I can think of; that is, the Court of Military Appeals and the District of Columbia Court of Appeals.

Our budget is basically the same. The Court of Military Appeals has three judges; the DC Court of Appeals has nine, and it has five senior judges in pretty much full service. Significantly, neither of those courts, despite our similarity of budget, pays any rent. Our court is going to have to pay rent, and I feel like somebody shooting at a moving target in dealing with GSA on that subject.

I included in our budget $1.2 million for rent. That was a figure I understood to be concrete at the time. The lease is still in negotiation. The word I got last is the lease is in the mail. You all know what that can mean. I understand there are some problems with it.

But the price has gone up. I have now learned that GSA has a little rakeoff on the top. I don't mean that disparagingly. Apparently it is regular course of business, but it was concealed or not apparent to me that that was so. So, Mr. Chairman, I'm afraid that I'm going to have to ask for another $600,000, because it is the rakeoff that goes to GSA, their surcharge, if you will. I'm not sure I could explain it, but I know the courtroom runs higher per square foot on their surcharge than other facilities within the court system.

In any event, our budget does break down into the four basic areas that my outline and my statement reveals.

I would conclude by simply saying this, which I will say to every appropriations or oversight committee hearing on the budget that I appear before: I ask for what the court needs and not for $1 more. I won't pad the budget. What the court needs will be determined, as best as I can do, by what will produce better decisions in a time consistent with justice to our American veterans.

Thank you.

[The prepared statement of Judge Nebeker appears on p. 160.]

Chairman **Cranston**. Thank you very much. I appreciate that statement. I appreciate its brevity and clarity.

First of all, I would greatly appreciate the court providing two copies of each of your slip opinions to the committee. I'm sure you understand the tremendous interest that exists throughout the country in the court and its decisions, and I have asked the committee staff to stay on top of the issues that come before the court so that they can serve as a resource to our constituents nationwide and for the Senate and also be responsive to areas that may need legislative resolution. You can do that, I assume?

Judge **Nebeker**. I can do that, sir. It may not be a slip opinion in the sense that you know them. We have arranged with any publisher to publish our opinions—West and Meade Data, Lexus, are very interested. Others, such as the Veterans Law Reporter, are also very interested. They will do the major publication and dissemination. West has not decided yet how to do it. I can guarantee you we will arrange to get from those who print it copies sent directly to you.

Chairman **Cranston**. I think maybe we're misunderstanding. I'm not really interested in the printed opinions, but in each of the slip opinions. Is it possible to provide those from each of the judges?

Judge **Nebeker**. I think we can provide you with a Xerox copy of the——

Chairman **Cranston**. Yes. You don't need to have them printed.

Judge **Nebeker**. As issued.

Chairman **Cranston**. As issued. Thank you.

The court's budget request includes $100,000 for support of the admissions committee, which is described as being comprised of 5 to 7 attorneys who will serve on a pro bono basis and 1 to 1½ FTEE for administration. How much more than the $100,000 requested would it cost to fulfill these functions entirely in-house?

Judge **Nebeker**. I don't know, sir, but I think it would be substantial. I think it would probably be three or four times that much. The value of pro bono service in this area is something I have witnessed in my years on the other court, and I really would question whether an admissions committee integrated into the court structure would be as valuable as one that is reflective of the members of the bar, including the members of the nonbar, if you will, who will be admitted to practice before the court.

Chairman **Cranston**. Thank you.

How much is anticipated to be collected in admission application fees in fiscal years 1990 and 1991?

Judge **Nebeker**. I have no idea. We have had probably 50 requests for forms by lawyers to be admitted to the bar. I'm confident that the number will far exceed that in the next few months for claims representatives of the various veterans service organizations who will want to be admitted to practice before the court. The application forms have just been completed. As soon as they are printed they will be sent out and made available to anyone who wishes to apply for admission. But I have, at this juncture, no idea. We did set a fee of $50, as I recall it, for admission to the Bar, which fund, of course, will be held in trust pursuant to the statute for training and discipline.

Chairman Cranston. Will the fees be used to support the admissions committee?

Judge Nebeker. No.

Chairman Cranston. Let me ask why not and how they will be used.

Judge Nebeker. They will be used to support educational activity for members of the bar. To the extent that we ever have any discipline problems—and I would anticipate none, unless it is a reciprocal discipline problem—the funds will be held strictly for what the statute calls for. They are not reverted funds; that is, they do not revert to the Treasury of the United States. They are held for statutory purposes by the court.

Chairman Cranston. You don't think the statute permits them to be used for the admissions committee?

Judge Nebeker. To bear the expenses of the admissions committee?

Chairman Cranston. Yes.

Judge Nebeker. It may be, sir. I don't know. I haven't thought of it that way.

Chairman Cranston. Why don't you take a look and just figure that out.

Judge Nebeker. All right.

Chairman Cranston. The original GSA estimate for general office space was $20 per square foot. What is the appraisal now of the cost for you to obtain permanent general office space not including the judicial offices?

Judge Nebeker. I'm not aware of a $20 estimate, sir. We are paying almost $30 where we are right now.

Chairman Cranston. That's what I wanted to know.

Judge Nebeker. That's a different kind of space than what we are talking about in the 34,000-square-foot accommodation we are looking for, and that's in the neighborhood of $45 a square foot.

Chairman Cranston. So you weren't aware of the $20, and therefore you do not know why it has gone up so much over the original projections?

Judge Nebeker. I know it has gone up because of market conditions.

Chairman Cranston. I note that your current projections for your permanent courtroom space are about $87 per square foot for the courtroom space as compared to GSA's initial estimate a year ago of $120 per square foot for high-ceiling space. Does this disparity mean you are not seeking courtroom space with high ceilings?

Judge Nebeker. Correct. Our ceiling will be about 11 feet, 6 inches. If the lease is negotiated, it will be on the top floor of the building. Two columns must be removed in order to make the room adequate otherwise, but we do have the ceiling height. It was architecturally not possible to punch through the ceiling, as I had hoped it would be.

Chairman Cranston. I'll have some posthearing questions for you, Frank, and I'd appreciate your doing your best to respond by the end of next week, if that is possible.

Judge Nebeker. Yes, sir.

Chairman Cranston. Thank you very much.

Jay, do you have any questions?

Senator **Rockefeller**. I don't have any questions. I just want to welcome you. That Court of Appeals is an extraordinarily important new court, and I really wish you well on it.

Judge **Nebeker**. Thank you, Senator Rockefeller. We will do our best.

Chairman **Cranston**. Thank you.

Judge **Nebeker**. Thank you, Mr. Chairman.

Chairman **Cranston**. Our next panel is composed of representatives of the four veterans' service organizations who prepared the Independent Budget as an alternative to the administration request. I want to congratulate AMVETS, DAV, PVA, and the VFW for your hard work and very fine product. The outstanding work that you began 4 years ago to focus on VA medical care has now expanded to encompass the VA budget.

The Independent Budget's analysis contains valuable insight into the concerns and priorities of a very significant portion of our collective Nation's veterans.

I know the members of this committee value your joint recommendation very highly, and we no doubt will be drawing from them in making our recommendations to the Budget Committee.

I now would like to welcome specifically Bob Jones, National Executive Director of AMVETS and Chairman of the Committee on the Independent Budget; Jesse Brown, Executive Director of the Disabled American Veterans; John Bollinger, Associate Legislative Director of the Paralyzed Veterans of America; and Larry Rivers, Executive Director of the Veterans of Foreign Wars of the United States.

This is a very distinguished panel of top officials. We are very honored that you are with us this morning.

As you have been informed, we have 10 minutes for the Independent Budget presentation and an additional 5 minutes for each of you as representatives of your individual organizations. We would be pleased to hear your testimony in part now. You do have 10 minutes.

However, as staff has advised you, I have to leave for travel out of town at about noon, and we have nine VA field witnesses here from out of town. I must be here to question them and receive their testimony, so we will have your 10-minute presentation of the Independent Budget now, and then I am going to have to ask you to yield to the two field panels. After that is finished, we will recall you for the testimony of your individual organizations.

Jesse and Larry, these are your first appearances before us in your new capacities, and we welcome you especially on this occasion. We welcome our friend Don Custis. Good morning. It is good to see you, as it is good to see all of you.

Now, if you would proceed for the 10 minutes, then we'll have you back later.

STATEMENT OF ROBERT L. JONES, CHAIRMAN, COMMITTEE ON THE INDEPENDENT BUDGET AND NATIONAL EXECUTIVE DIRECTOR, AMVETS

Mr. **Jones**. Mr. Chairman, I thank you for this opportunity to present an overview of funding requirements for the Department of

Veterans Affairs based upon our independent assessment of veteran needs.

As you are aware, this is the 4th year that we have developed this independent assessment, and each year we gain a firmer grip on the issues confronting veterans and what is necessary to ensure that veterans receive the benefits to which they are entitled in a timely, cost-efficient manner.

We compliment Secretary Derwinski for the obvious positive impact that he has had on the administration's budget. We will share in the presentation of the Independent Budget requirements for fiscal year 1991: Mr. Larry Rivers of the Veterans of Foreign Wars will present the construction portion; I will present the National Cemetery System program; Mr. Jesse Brown of the Disabled American Veterans will present the general operating expenses and veterans' benefits portion; and Mr. John Bollinger of the Paralyzed Veterans, accompanied by Dr. Custis, will present the medical programs.

Mr. Chairman, with your concurrence I would request that the Independent Budget for fiscal year 1991 be made a part of the record, sir.

Chairman CRANSTON. Of course.

Mr. JONES. With that, sir, Mr. Rivers.

[A copy of the Independent Budget is retained in the committee files.]

[The prepared statement of Mr. Jones appears on p. 161.]

STATEMENT OF LARRY W. RIVERS, EXECUTIVE DIRECTOR, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. RIVERS. Thank you, Mr. Chairman.

It is a pleasure to be here and to have a chance to actually testify for the first time before this committee.

The VFW responsibility doing the Independent Budget portion was primarily with the construction program. The construction portion of the Independent Budget is very short—barely 4½ pages. I know the members of this committee will have the opportunity to read those 4 pages, and hopefully other Members of Congress will, as well.

Basically, our principles and guidelines are set out on the first page. There are 12 of them. The first two, naturally, are ones we consider most important. Of course, first is that we can actually ensure the integrity of the VA system through appropriate budget appropriations. Second, that the facilities that we plan are actually built and constructed in time to meet the needs of veterans it intended to serve, along with the 10 others that are listed.

Very briefly, Mr. Chairman—and I will move very quickly, because the portion dealing with health care, of course, is very important, as is the portion Mr. Brown will address.

Within the Independent Budget we have a major construction recommendation of some $666 million versus the administration proposal of some $530 million. Among the $666 million recommendation that we make, we ask that some $42 million of that be allocated for advanced planning. You will note that that is some $20 million more than has been requested by the administration. We believe a more generous allocation to the advanced planning and design fund would accelerate future construction. We believe this larger figure would ensure a larger number of projects actually becoming a reality, and we think we'll need those as we deal with our aging veteran population.

We have requested in the Independent Budget some $32 million to be allocated to construct new VA nursing homes. We think that is necessary to address the aging veteran population and how we are going to deal with the aging veteran situation.

We advocate funding that would permit the VA to construct four 120-bed nursing homes this year, and we will need further construction in other years. We do applaud the decision to construct the one nursing home in Palm Beach, FL. As you will recall, last year we asked for the construction of two nursing homes. We had none. Thus, the request for the four this year is to make up for the backlog that has now occurred in that area.

Finally, our major construction proposal includes some $6.3 million to acquire land for national cemeteries in States that now do not have open facilities. We believe that meets with what is contained in the fiscal year 1991 medical construction requirement, and we think those recommendations are very valid.

Regarding minor construction, we recommend some $285 million—almost double what the administration has requested. You will note that we exceed the 1990 appropriation quite significantly, and this reflects the growing concern of the members of the Independent Budget for the urgent need for updating and repairing existing VA facilities.

Most of the minor construction funds—some $210 million—are, indeed, identified with medical construction. Of that amount, some $42 million would be designated exclusively to convert unused medical center beds to nursing home care.

We have modest amounts within the minor construction appropriation to support the VA regional offices and existing national cemetery construction—fiscal year 1991 Independent Budget recommendation of some $5 million and $10 million respectively for those purposes.

In another area of minor construction, funds for the VA construction staff, we think that would permit staffing at current levels, as in keeping with the recommendation that the VA take appropriate steps to establish national construction priorities and to improve construction planning.

Thank you, Mr. Chairman. That very briefly concludes an overview of the construction programs. I would now yield back to the Chairman, Mr. Jones.

[The prepared statement of Mr. Rivers appears on p. 163.]

Chairman CRANSTON. Thank you very much. I do want to remind you you've got about 5 minutes left.

Mr. JONES. Yes, sir.

Mr. Chairman, in last year's Independent Budget the service organizations observed that we were favorably impressed with the manner in which the National Cemetery System is managed. We remain so, given the budgetary support. The Cemetery System has demonstrated it can do its job well within the fiscal constraints placed upon it.

Unquestionably, the Cemetery System's workload will increase significantly through the foreseeable future and additional staffing and funds for new equipment and equipment maintenance obviously are necessary to accommodate that increased workload.

The VA's 1991 budget submission does request an increase of $6.5 million, which includes funding for 52 additional staff and $2.2 million for equipment replacement.

We recommend an increase of $15 million, which includes funding for 92 additional staff, and $6 million to alleviate the equipment backlog.

They must have the resources to provide efficient and compassionate services to deceased veterans and their families. We do not believe, given the current resources requested by the administration's budget, that will occur. As Mr. Rivers has already testified, sir, our Independent Budget does include $16.5 million for acquisition of land for new cemeteries, maintenance, and repair of existing cemeteries. This is in addition to the $6.5 million requested by the administration.

Sir, I yield to Mr. Jesse Brown of the DAV.

STATEMENT OF JESSE BROWN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. **Brown**. Thank you, Mr. Chairman.

I request that my entire statement be entered into the record.

Mr. Chairman, the DAV prepared the Veterans Benefits Administration (VBA) portion of the Independent Budget, and I will attempt to highlight that very quickly.

Over the past decade, VBA's components have been plagued by FTEE reductions attributed to ADP modernization "savings." The consequences of these reductions have come home to roost in that the delivery of benefits and services to our Nation's veterans are grossly inadequate and will deteriorate further if the limited resources requested by VBA in the fiscal year 1991 budget are provided.

The administration's budget request provides a decrease of 266 VBA FTEEs. How can fewer employees stop further deterioration in the current unacceptable level of services to veterans illustrated by an increase in the compensation and pension claims backlog from 167,000 in 1987 to over 670,000 in 1989, with a corresponding deterioration of quality and timeliness of claims adjudication?

I understand that there is a controversy regarding the backlogged claim figures, but we stand by our assessment of them. We think that they are clearly supported by data we've obtained from VA's official accounting system.

Further, we are concerned that 1.7 million veterans a year are unable to reach a veterans' benefit counselor by phone, and there are intolerable delays in vocational rehabilitation services. It takes 100 days for a veteran simply to be interviewed following application for vocational rehabilitation. We don't think that's right.

The reasons are clear, Mr. Chairman. Compensation and pension adjudication personnel have been reduced 39 percent over the last decade. Over 50 percent of CP&E operations are not fully integrated with ADP operations. During fiscal year 1989 nearly 20 percent of adjudication personnel nationwide were trainees: 50 percent in Milwaukee and Denver, 44 percent in Chicago, and 42 percent in St. Louis. Stated bluntly, VBA's operations must be adequately staffed and funded to provide timely and quality service to our Nation's veterans as intended by Congress.

The cornerstone in restoring good service to veterans is adequate funding for the newly revitalized ADP modernization program with an immediate infusion of FTEEs to reverse this deterioration.

For VBA, the primary recommendation of the Independent Budget is an immediate increase of 734 FTEEs to be deployed in the following components: veterans' services, 195; CP&E service, 365; loan guaranty, 105; and vocational rehabilitation counseling, 69. These additional FTEEs should be provided by a 1990 supplemental appropriation and maintained through 1991. The annualized cost of this recommendation is $25 million, or less than $1 for each of the Nation's 27.1 million veterans.

Mr. Chairman, that ends my testimony.

[The prepared statement of Mr. Brown appears on p. 165.]

Chairman CRANSTON. Thank you.

John, very briefly proceed.

Mr. Bollinger. All right, sir.

STATEMENT OF JOHN C. BOLLINGER, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY DR. DONALD L. CUSTIS, SENIOR MEDICAL ADVISOR TO THE INDEPENDENT BUDGET

Mr. BOLLINGER. Thank you, Mr. Chairman and Senator Rockefeller. I am pleased to present the health care portion of the Independent Budget.

As you know, for veterans' medical care, alone, the proposed budget is $12.3 billion for fiscal year 1991—certainly a big increase over what we have been used to in past years.

They are grand figures, indeed. Just comparing absolute dollars to other Federal entities, it would appear that veterans got their fair share for 1991. But, as Secretary Derwinski speculated several months ago, veterans' service organizations will probably not be content with the President's budget, nor should they be. Secretary Derwinski, you're right about that. But it must be understood that our unwillingness to declare a victory based on the President's improved health care budget is because the Independent Budget recommendations for funding levels are based on actual need and projected demand, not on available dollars.

Unlike OMB's dollar-driven budget snapshot, which is retried each year without regard to cumulative deficits and program services, the Independent Budget has based its recommendation on a carefully projected analysis of what services need to be provided, how many veterans will need those services, and what those services will cost.

I know my time is very limited, Mr. Chairman. Health care is certainly an important issue to our organizations. If I could just give you a very brief glimpse of a recent survey that we did just to bring you up to date on where health care is, maybe we can see how——

Chairman CRANSTON. Time is up. If you can do that in about 1 minute flat, fine. You each will have a chance later on. I'm sorry to inconvenience you this way, but you will have another opportunity this morning.

Mr. BOLLINGER. OK. It will take me a minute to find it.

In November the Independent Budget staff conducted a telephone survey of 24 representative VA medical centers. It was like our survey in the fall of 1987 which first sounded the alarm on true VA shortfalls. The survey questions were designed to elicit information on any continuing impact of a residual of fiscal year 1989 funding shortfall and the system's ability to handle the projected continuing shortfall in fiscal year 1990.

Every hospital we talked to reported that deficits were still being absorbed by workload cutbacks and use of funds intended for equipment purchase, building maintenance and repair, personal salaries, and contract health care services such as community nursing homes. The list goes on and on. As you know, I could continue for at least 10 more minutes.

I would just conclude my statement at this time by saying it is not just the VA health care system that is suffering; it is the tens of thousands of veterans who served in defense of this Nation that look to the VA for health care that they desperately need and deserve. We hope that Congress will restore these much-needed funds to the President's budget.

Thank you.

[The prepared statement of Mr. Bollinger appears on p. 181.]

Chairman CRANSTON. Thank you very much.

I want to say you have already had a considerable impact on what is happening today, because we did have time to examine your Independent Budget and that led to many questions we have already asked of the VA. I appreciate it. Thank you for your tolerance and understanding. We'll get you back to the table later.

I now want to call on the very distinguished VA field medical officials who will be with us. The panel consists of one chief of staff, Dr. Stanley Geyer from Seattle, and three hospital directors: Barbara Gallagher from Baltimore; Joseph Moore from Lakeside, Chicago; and Malcom Randall from Gainesville, FL.

As you are coming to the table, let me note that you were not asked to provide prepared statements; instead, you have been asked to be here to respond to questions with which we will now proceed. Generally, the question will be directed to all of you unless I indicate otherwise.

Again, I want to express my great thanks to each of you for traveling to be with us. Barbara, we appreciate your coming, although not a great distance, on such very short notice. We much appreciate the work you are all doing and your courageous willingness to come here to enlighten the committee under some rather tense circumstances.

I hope we cleared up earlier with Secretary Derwinski any misapprehensions anyone might be having about any adverse consequences from providing your truthful information to the committee.

I will now ask each of you to rise and raise your right hand so you can be sworn in.

Do you swear or affirm that the testimony you will give to this committee at this hearing today, and any written answers or statements you provide to this committee in connection with this hearing will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in affirmative.]

TESTIMONY OF BARBARA L. GALLAGHER, DIRECTOR, VA MEDICAL CENTER, BALTIMORE, MD; DR. STANLEY J. GEYER, CHIEF OF STAFF, VA MEDICAL CENTER, SEATTLE, WA; JOSEPH L. MOORE, DIRECTOR, VA MEDICAL CENTER, CHICAGO (LAKESIDE), IL; AND MALCOM RANDALL, DIRECTOR, VA MEDICAL CENTER, GAINESVILLE, FL

Chairman CRANSTON. Malcom, we welcome you back as an old friend. Senator Graham regrets that he is not here yet.

Mr. RANDALL. Yes, sir.

Chairman CRANSTON. Now to the questions.

As a lead-in, have you been instructed by Central Office as to the testimony to provide here this morning?

Mr. RANDALL. Not at all. We did have meetings yesterday with some of the Central Office people, but the tenor of the conversation was to state what you believe is the fact.

Chairman CRANSTON. Do each of you agree with that characterization?

[Chorus of yeses.]

Chairman CRANSTON. If you at any time become concerned about retaliation because of your testimony here, I ask you not to hesitate to contact me directly.

Mr. RANDALL. Yes, sir.

Chairman CRANSTON. To begin, would you each please tell the committee the number of years you have had with VA and generally where you have served--just very briefly. We'll start with you, Malcom.

Mr. RANDALL. I have had about 45 years of experience with the VA and have served pretty much all over the country with one tour in the Central Office. I am now at Gainesville, FL.

Chairman CRANSTON. Joseph.

Mr. MOORE. On Friday I will start 34 years. I have served at 12 medical centers and in Central Office.

Chairman CRANSTON. Stanley.

Dr. GEYER. For 12½ years. I was formerly the chief of staff at the VA Pittsburgh University Drive. I am currently the chief of staff at the Seattle VA.

Ms. GALLAGHER. I have served 20 years. I most recently was the hospital director at Perry Point, and now at the Loch Raven facility in Baltimore.

Chairman CRANSTON. Joe, are you about to receive an award—the first VA official to receive it—for distinguished Federal service?

Mr. MOORE. Yes, sir, Mr. Chairman.

Chairman CRANSTON. Great. Thank you.

At our oversight hearings in September 1988, and again in 1989, I asked panels of regional directors, hospital directors, and chiefs of staffs and services whether the fiscal situation they faced was a crisis, and virtually all said that indeed it was. At each of your facilities a year ago were you in a fiscal crisis, and was it the worst fiscal crisis you had experienced in VA? Could you each briefly answer that question? I'll again start with you, Malcom.

Mr. RANDALL. At Gainesville yes, it was a crisis and it was the worst crisis that I had faced in all the years I had been in the VA.

Chairman CRANSTON. Joe.

Mr. MOORE. Yes.

Chairman CRANSTON. Stanley.

Dr. GEYER. I wouldn't call it a crisis, but it was certainly a severe situation.

Ms. GALLAGHER. Certainly a crisis at Baltimore.

Chairman CRANSTON. Let me start with you, Barbara, and work the other way across the table. Generally, is your fiscal situation better than, about the same as, or worse than a year ago now?

Ms. GALLAGHER. It is the same as it was a year ago.

Chairman CRANSTON. Same.

Dr. GEYER. Ours is approximately the same.

Mr. MOORE. We are better than we were a year ago because I can't say we are in crisis now. We were then.

Mr. RANDALL. I think we're a little better than a year ago. Part of that is due to the supplemental appropriation that the Congress passed because we were able to replace our stocks and our stores that had been cannibalized, and we entered this fiscal year in good shape in terms of we had minimal backlogs of equipment. Had it not been for the supplemental appropriation, we would have been in more serious trouble this year.

Chairman CRANSTON. Joe, is that about the same with you?

Mr. MOORE. Yes, sir.

Chairman CRANSTON. Again, starting with you, Barbara, how about as compared to 2 years ago? Better, about the same, or worse?

Ms. GALLAGHER. I would say a little better than 2 years ago, but certainly last year and this year have been crisis years.

Chairman CRANSTON. Stanley.

Dr. GEYER. I think we are a little worse than we were 2 years ago. Our employment has dropped some. We have more older equipment that needs to be replaced. There are new technologies that are developing that we have trouble responding to. So I think our situation has probably deteriorated slightly compared to 2 years ago.

Chairman CRANSTON. Joe.

Mr. MOORE. I would say we are about the same as 2 years ago.

Mr. RANDALL. I think we are about the same as 2 years ago.

Chairman CRANSTON. Now, specifically, would you each please compare the situation at your facility today with the situation 1 year ago and 2 years ago with particular emphasis on each of the following—which are the things I went through with Secretary Derwinski nationally. We'll go through one aspect at a time through the entire panel.

First, the number of patients being furnished hospital care now as compared to a year ago and 2 years ago.

Ms. GALLAGHER. I would say that the number is less because we are able to afford less.

Dr. GEYER. Our numbers have remained——

Chairman CRANSTON. Is that for both years?

Ms. GALLAGHER. That's for both years.

Dr. GEYER. Our numbers have remained constant from fiscal year 1988–89 and what we project for fiscal year 1990.

Mr. MOORE. On the basis of patients treated, now we are treating less than we did a year ago and 2 years ago. On our outpatient basis, we are treating more patients than we did a year and 2 years ago.

Chairman CRANSTON. We'll get to outpatients later.

Mr. MOORE. OK.

Chairman CRANSTON. Malcom.

Mr.T4 Randall. On the inpatient side we are treating about the same number that we did in fiscal year 1988 and the plan for 1990.

Chairman CRANSTON. Next, the number of patients being furnished, and the duration of, nursing home care.

Ms. GALLAGHER. I would say that last year we were in a better position in nursing home care than we are this year. We now have 34 placements planned for this year, but our numbers are decreasing because of budget constraints.

Dr. GEYER. We are providing fewer patients with nursing home care treatment in our facility than we did 2 years ago, about the same as last year. Our community nursing home census has declined over the 2 years.

Chairman CRANSTON. Joe.

Mr. MOORE. We have taxed social work a great deal to become imaginative because we have had to shorten lengths of stays in community nursing homes in order to accommodate the number of patients that we need to place. So there is a variance within the 6-month period versus just a standard 6-month placement.

Chairman CRANSTON. Malcom.

Mr. RANDALL. We have fewer dollars than we did last year for community nursing home placements, and therefore our placements are down. We have attempted to make shorter placements than 6 months in order to get more mileage out of the dollars available.

Chairman CRANSTON. You didn't respond on the duration. Let me go back to you, Barbara. How does that compare.

Ms. GALLAGHER. You mean the month of placement? Is that what you want?

Chairman CRANSTON. No, duration in community home care.

Ms. GALLAGHER. I'm still not understanding.

Chairman CRANSTON. Nursing home care.

Ms. GALLAGHER. We are placing our patients for 3 months. Is that what you are referring to?

Chairman CRANSTON. How does that compare to a year ago or 2 years ago?

Ms. GALLAGHER. I'm sorry. Yes. We were able, 2 years ago, to place the patients for 6 months; now we have had to go to three-month placements over the last 2 years.

Dr. GEYER. We, likewise, have decreased placement time from 6 months to 3 months.

Mr. MOORE. As I said earlier, we vary. We started certainly from 3 months. That is different than it was previously.

Mr. **Randall**. Previously it was 6 months, and we attempt to make placements shorter than that now—anywhere from 2 months to 4 months, depending on the individual need.

Chairman **Cranston**. Let me reverse now and start with you, Malcom. The number being furnished outpatient care?

Mr. **Randall**. Outpatient care? We dropped, in the last fiscal year, as a result of the pressure on funds, and we are anticipating we are going to be back up to about where we were in fiscal year 1988—we are planning on about 220,000 visits per year. In fiscal year 1988 we had 217,000 visits.

Chairman **Cranston**. Joe.

Mr. **Moore**. We are treating more outpatients because we opened a year ago a clinic in Crown Point that we had 42,500 for the capacity. We have reached the capacity at Crown Point in 1 year, so that we have overall, between Lakeside and Crown Point, we are treating more patients than we did previously.

Chairman **Cranston**. What is the situation just at Lakeside?

Mr. **Moore**. We are treating probably less because we are looking at whether or not those patients, without any danger to care, can be dropped from our rolls to accommodate where we need to be in the categories of patients.

Chairman **Cranston**. Stanley.

Dr. **Geyer**. In fiscal year 1988 the Seattle VA accomplished 194,439 veteran visits. In fiscal year 1989 we had 190,112 veteran visits. We anticipate approximately 185,000 veteran visits in fiscal year 1990. That's a steady decline of about 2 percent per year.

Chairman **Cranston**. Did you say 2 percent?

Dr. **Geyer**. Per year of veteran visits.

Chairman **Cranston**. Barbara.

Ms. **Gallagher**. Our outpatient visits are escalating. Last year we saw 172,000; this year we are anticipating 180,000. We are looking at it with some consternation since we don't have the funding for it.

Chairman **Cranston**. What was it in 1988?

Ms. **Gallagher**. In 1988 it was 165,000.

Chairman **Cranston**. Back to you, Malcom. The vacancy rate and turn-over rate for doctors, nurses, and other scarce health professionals?

Mr. **Randall**. Fortunately we don't have much of a problem with anyone except nurses. Our affiliation with the University of Florida means that they take responsibility for helping us recruit physicians. Nurses are a real problem. I don't know precisely what the turnover rate is, but our vacancy rate right now probably runs about 15.

Chairman **Cranston**. Joe.

Mr. **Moore**. Nursing in Chicago is a problem for not only the VA; it is for the private sector, as well. For our nurses, the demands are greater. And so, in addition to that, we are the only facility in Chicago that has paid parking, so that we charge our nurses for that, and that increases our turn-over rate.

Physician staff is not particularly a problem except those specialties that we cannot compete very well with, such as radiology. There are other allied health professionals in rehabilitation medicine that we do have difficulty retaining and recruiting because of the salary structure.

The percentage, Mr. Chairman, I would say overall our turn-over rate tends to be, hospital-wide, about 25 percent.

Chairman CRANSTON. How does that compare to a year ago and 2 years ago?

Mr. MOORE. We had the same problem a year ago. We have been recruiting for a chief of radiology, with a brief interim period of 6 months that we had one, for 5 years. Our nursing shortage has been great for the last 2 years.

Chairman CRANSTON. I want to remind you all to try to give us a comparison to last year's and the year before.

Stanley.

Dr. GEYER. Seattle is a relatively privileged health care market. We have little difficulty recruiting for most health care providers. We occasionally experience some difficulty recruiting psychiatrists. That has been particularly more severe this year than in the past. I am anticipating some difficulties recruiting radiologists during the coming fiscal year. Otherwise, we have a fairly stable staff in physicians and nurses.

Chairman CRANSTON. Barbara.

Ms. GALLAGHER. We have considerable difficulty with anesthesiologists, with nursing, with psychiatrists, with all of the allied health professionals. We have had that difficulty over the last year and the year before that.

We have contract nurses, which costs us a great deal of money, plus the overtime of our nurses. We have tried to do either/or, but we can't because of the nurse shortage.

We have not lost as many nurses. The turn-over rate this year isn't as bad because the morale is going up in our nursing service because we are looking forward to a new hospital, a replacement facility, in 1992. So that's, I think, helping us to keep our nursing staff.

But we have difficulty in all areas of allied health—especially in the Baltimore area, because our salaries are not competitive.

Chairman CRANSTON. Next, Malcom—and, again, comparison to the 2 years—the competitive nature of your salary structure.

Mr. RANDALL. It is not competitive at all, and it is getting increasingly worse.

Chairman CRANSTON. How was it compared to—how different is it from last year and the year before?

Mr. RANDALL. It is worse this year than it was last year and it keeps getting worse each year.

Chairman CRANSTON. Joe.

Mr. MOORE. I think that I would agree with Malcom that for each year it just tends to—the gap gets wider and we cannot compete.

Chairman CRANSTON. Stanley.

Dr. GEYER. For some areas it is downright lousy. For some specialty surgeons we cannot hire full-time surgeons. We are unable to hire our own anesthesiologists. I am currently negotiating a contract for radiologists. For some other subspecialty areas in medicine, particularly for those people that perform procedures——

Chairman CRANSTON. How does that compare?

Dr. GEYER. Significantly worse this year, and it has been getting worse over the last 4 or 5 years.

Ms. GALLAGHER. And I would say the same. We are worse this year than we were last year.

Chairman CRANSTON. Starting with you now, Barbara: what about staff morale compared these 2 years?

Ms. GALLAGHER. Well, Baltimore is unique. Our morale has been low—quite low—because we have not had the funding we have needed over the last 3 years, I think. We are feeling better for the anticipation of the 1991 budget, certainly. And, as I said, we will hopefully have some activation positions as we move into the new facility. So morale is getting better.

But, in general, I do not think the morale is good.

Dr. GEYER. The morale in Seattle is generally good, but it is particularly changing among the physician staff because of the decline in competitiveness of the pay.

Chairman CRANSTON. Is it getting worse?

Dr. GEYER. It is getting worse.

Chairman CRANSTON. Over each year?

Dr. GEYER. There are two factors that contribute to a decline in morale for the doctors: one is the salary, the second is the perceived lack of support for biomedical research.

Chairman CRANSTON. Joe, please try to be brief in your response.

Mr. MOORE. I would say the morale is high, except for physicians and nurses.

Chairman CRANSTON. How does it compare to the 2 years?

Mr. MOORE. Compared to 2 years ago, it is worse than it was then because we have not had what we need.

Chairman CRANSTON. Malcom.

Mr. RANDALL. I'm reminded of Dickens: "It was the best of times and the worst of times, a season of light and a season of darkness, the spring of hope and the winter of despair."

Now, 1989 was the winter of our despair. I have never seen a more dispirited work force than in that fiscal year.

The spring of hope is if the 1991 budget is true and if we can count on an increase in funds in out-years. Then I think morale will improve tremendously.

But the roller coaster kind of track that we have been on for years is demoralizing to the troops and we are not going to really address that until we can get a stable, progressive budget that keeps up with the cost of health care.

Chairman CRANSTON. Back to you, Barbara, on drug stocks. How do they compare over these 2 years?

Ms. GALLAGHER. Pardon me? I didn't hear you.

Chairman CRANSTON. Drug stocks. How do they compare over the 2-year period. Your supply of drugs.

Ms. GALLAGHER. I'm sorry. I would say that our supply of drugs is not good. It is low this year—lower than last year. Again, it is the budget problem.

Dr. GEYER. It is relatively unchanged in Seattle.

Chairman CRANSTON. Joe.

Mr. MOORE. I would say it is unchanged.

Mr. **Randall**. Our picture is better right now because we were able to use the supplemental appropriation in 1989 to replace our depleted drug stock.

Chairman **Cranston**. I've got three more of these. The next is the replacement equipment and new equipment backlog.

Ms. **Gallagher**. Yes. We have no replacement equipment at our hospital at this point in time because that was stopped because of the new hospital. So I can't answer that adequately.

Chairman **Cranston**. Stanley.

Dr. **Geyer**. I brought with me a 20-some page list of equipment that we need to buy at the Seattle hospital.

Chairman **Cranston**. How was it 1 and 2 years ago?

Dr. **Geyer**. It was better 1 year ago and much better 2 years ago because we have a relatively new building.

Chairman **Cranston**. Didn't you get money at the end of 1989?

Dr. **Geyer**. We did get money at the end of 1989, but we used the money mainly for the purchase of inventory and some for equipment.

Chairman **Cranston**. Joe.

Mr. **Moore**. Replacement equipment continues to be bad for us. New equipment gets worse each year. There are new requirements for us to think about universal precautions, which then taxes an already taxed new equipment acquisition.

Chairman **Cranston**. You say it gets worse each year?

Mr. **Moore**. I think so. It did this year in comparison to last year and the year before that.

Chairman **Cranston**. You said you're better off?

Mr. **Randall**. New equipment is a problem, but, again, the supplemental appropriation—we invested heavily in equipment when we received the supplemental at the end of the year.

Chairman **Cranston**. So you are better off than in those other 2 years?

Mr. **Randall**. Yes, sir.

Chairman **Cranston**. The next-to-the-last question is maintenance and repair. Barbara.

Ms. **Gallagher**. Well, again, because we are having a new hospital we spent little money on that.

Chairman **Cranston**. Yes. Stanley.

Dr. **Geyer**. Our maintenance and repair is largely unchanged.

Mr. **Moore**. The same.

Mr. **Randall**. The same.

Chairman **Cranston**. Finally, prosthetics.

Ms. **Gallagher**. In prosthetics we are doing well. We are making sure that our prosthetic backlog is down. We are stretching to do that, but we are making sure the veterans have what they need.

Chairman **Cranston**. Better than last year?

Ms. **Gallagher**. Better than last year. Yes.

Chairman **Cranston**. Stanley.

Dr. **Geyer**. Worse than last year.

Mr. **Moore**. Better than last year.

Mr. **Randall**. Our prosthetic costs are down, but I think that is more because of aggressive management of the program to make certain that we are not wasting money.

Chairman **Cranston**. Is it better than last year?

Mr. **RANDALL**. Yes, sir.

Chairman **CRANSTON**. Jay, do you have any questions?

Senator **ROCKEFELLER**. No questions.

Chairman **CRANSTON**. Let me ask each of you this question. I'll start with Malcom. Very brief answers, please.

What is the biggest difficulty you are facing at your facility in dealing with the current funding levels?

Mr. **RANDALL**. The problem is that Florida is unique in turning away people who apply for care, and who have received care in other States before moving to Florida, who feel that they are entitled to care. This causes a lot of unhappy veterans who feel that we are not meeting their needs. It is a recurring, everyday problem.

Chairman **CRANSTON**. Let me ask—without giving much detail—what is the worst problem you face in your facility due to the budget constraints?

Mr. **RANDALL**. Controling the workload.

Chairman **CRANSTON**. What about you?

Mr. **MOORE**. I would agree with Malcom.

Dr. **GEYER**. I wouldn't say controlling the workload. I would say responding to the demand that shows up at our front door.

Chairman **CRANSTON**. Any particular demand you have the biggest problem with?

Dr. **GEYER**. I think the demands across the board. We have trouble responding in all clinics and all inpatient areas.

Ms. **GALLAGHER**. Ours would be the same—response to inpatient demand. We have to curtail some elective surgeries, hip replacements, etc. That would be our biggest problem.

Chairman **CRANSTON**. Over half the Senate is urging President Bush to send forth the supplemental request for the current fiscal year, but there is certainly no guarantee that one will be forthcoming. I would like to know what the result would be at your facility if no additional funds are provided this fiscal year. Malcom.

Mr. **RANDALL**. Well, we are going to get through, but it is going to be tight and it is going to be close and we are going to have to carefully manage every dollar that we have.

Chairman **CRANSTON**. And not do some things you would like to do.

Mr. **RANDALL**. That's correct.

Chairman **CRANSTON**. Joe.

Mr. **MOORE**. Money is always wonderful, Mr. Chairman, but we will manage.

Dr. **GEYER**. We anticipated that there would not be a supplemental, so we have already prepared to diminish the workload slightly. We'll make it through the year.

Ms. **GALLAGHER**. We, too, have the responsibility to manage. We will make it, but we may have to ask the regional director for some help.

Chairman **CRANSTON**. Thank you very much. I have more, but I'm going to yield to Senator Graham.

Bob, we welcome you.

OPENING STATEMENT OF SENATOR GRAHAM

Senator **Graham**. Thank you very much, Mr. Chairman. I regret that I could not be here earlier. I have an overall statement on the budget which I would like to submit for the record.

[The prepared statement of Senator Graham appears on p. 150.]

Senator **Graham**. I would like to take, however, a minute to highlight a few particular items in the administration's budget request. On the issue of reorganization of the management structure of the Veterans Health Service and Research administration, I understand that the Secretary has, as one of his principal concerns, the inconsistency in medical care across the country. Our office receives numerous letters from veterans who have moved to Florida and find the availability of care severely lacking compared to the care available in their home State. So if that is a motivation, a desire to achieve a parity of medical services for American veterans without regard to where in the country they might live, it is a concern that we deeply share.

My concern is that this is not so much an issue of organization as it is an issue of resources.

Mr. Chairman, when I sat in our State Senate I used to have under the glass on my desk a statement by an Athenian general of 300 B.C. which, summarized, stated that whenever the Athenian army was in the greatest point of peril and the greatest jeopardy of annihilation, it was then that the general's staff back in Athens would determine it appropriate to reorganize the army. I wish I had that quote to submit for the record, but I think it grasps sometimes the tendency to face a difficult problem with a reorganization solution.

I would suggest, in fact, that the VA district and regional offices providing specific demographic and service availability information have helped to highlight issues of inconsistency of service.

In my previous position as Governor, and particularly now as a Member of the Senate and a member of this committee, I have particularly benefited by the close counsel of Mr. Malcom Randall and the excellent and sustained period of effective planning for health care services for veterans within his district responsibility. The district office has allowed there to be a close integration of public and private health care planning at the local, State, and national level. It has assisted in calming what could have been intrastate conflicts over where medical facilities should be provided.

I am concerned that that quality of effective planning and coordinated relationships which have flowed from it not be lost in a reorganization structure.

These district and regional offices are an important link between the District of Columbia Central Office, individual medical facilities, State veterans' agencies, and veterans' service organizations. I know that the office for Medical District 12 could stay busy just fielding questions from the 21 congressional offices.

I sympathize with the Secretary's interest in streamlining operations and achieving cost savings in administration; however, I am concerned that one office in Jackson, MS, may not have the resources, personnel, and institutional knowledge necessary to adequately represent the needs of veterans in that State and 10 others.

The proposed region III would encompass 45 VA hospitals, 71 outpatient facilities, and 7.3 million veterans. Will such an office truly be able to provide the detailed analysis and information needed for policymakers?

These concerns, Mr. Chairman, are shared by a number of Representatives and Senators. I would like to ask consent to submit for the hearing record comments from eight other Members of Congress on the reorganization plan.

Chairman CRANSTON. Yes.

[The comments from other Members of Congress appear in the appendix.]

Senator GRAHAM. All of us respect the goals of this plan; we would just like an opportunity to reevaluate the method for achieving these goals.

Mr. Chairman, I may submit questions in writing for the Secretary concerning such issues as his willingness to reconsider the number of regional offices; what would be the effect of this reorganization on a continuation of the medical district system, perhaps on a more informal basis; and, finally, an analysis of the budget, as submitted, within the current organizational structure as it moves to achieve parity of services for all American veterans.

Mr. Chairman, if I could I have a few questions that I would like to ask particularly to Mr. Randall.

Chairman CRANSTON. Certainly.

Bob, I want to say on the reorganization I respect the diligence you are applying to take a look at that, and I'd like to explore with you at some point what we feel is the best approach.

Senator GRAHAM. Before I turn to Mr. Randall's questions, I assume that all the members of the committee have been provided with this map which shows the proposed reorganization?

Chairman CRANSTON. Yes.

Senator GRAHAM. I'm not certain who was responsible for developing this map. There is one area of parochial curiosity that I have. Along the southern boundary of this map are various rectangles which contain areas like Guam, the Philippine Islands, and then the States of Alaska and Hawaii, the Commonwealth of Puerto Rico, and the Virgin Islands. And then there is a box that contains Key West Island. [Laughter.]

Chairman CRANSTON. What's wrong with that? [Laughter.]

Senator GRAHAM. In fact, it actually comports with a significant and overlooked historical development. The Key West Islands and some adjacent islands in the Florida Keys united under the title of the Conch Republic and seceded from the United States in 1981. That secession had not previously been recognized by the U.S. Government. [Laughter.]

I am forwarding this map to the current leaders of the Conch Republic as a statement of acceptance, and I would assume surrender. [Laughter.]

I do not know what effect this is going to have on such installations as the Boca Chica Naval Air Station, whether we are also transferring title to that and other important Federal installations in the Conch Republic.

But I would say one thing that this has accomplished: the bearded dictator in Havana who used to be 90 miles off our shore is now 120 miles off our shore. [Laughter.]

Chairman **CRANSTON**. Since Ed Derwinski was Undersecretary of State and it was prepared by the VA, I assume there must be something correct about all of this.

Senator **GRAHAM**. I assume so. We'll look forward to the repercussions from this. [Laughter.]

Mr. Randall, at the hearing that we held, the field hearing of this committee in Orlando, last year there was considerable discussion about the question of the gaps in accessibility to VA service in your district. How would you compare the current State of service delivery and that which is contemplated under the budget that has been submitted by the department to that which you have been able to provide in the recent past? Would the budget, as submitted, help in closing some of those gaps, keep them about as they were, or make them wider?

Mr. **RANDALL**. Are you referring to the fiscal year 1991 budget?

Senator **GRAHAM**. Yes.

Mr. **RANDALL**. That should help provide some service that we are not now providing. One of the encouraging things is that I think the Chief Medical Director and the Secretary have made a commitment to equity of access across the country. We currently have the highest number of service-connected outvisits of any medical district in the country, and so the fall-out of that is that the non-service-connected outpatient is squeezed out. We are not able to provide him with care.

So I think the fiscal year 1991 budget is going to enable us to increase outpatient treatment, which is the real crunch. And, in addition, with the commitment to equity of access I am hoping that funds will be adjusted within the system to help us.

Senator **GRAHAM**. Turning to the organization questions, could you describe the type of contact that you, as a district director, have with individual medical facilities, veterans' service organizations, the Florida Department of Veterans Affairs, as well as other health care providers and institutions?

Mr. **RANDALL**. Well, I think we have been fortunate in Medical District 12 in that we have been able to have continuous contact with the Florida Department of Veterans Affairs, with the leadership of veterans' organizations at the State level, and with the congressional delegation. That ongoing kind of dialogue has enabled us to exchange information and to provide demographic kinds of data so that I think everyone in Florida who had an interest in veterans' affairs knew what we were doing.

And, as you pointed out, it was this networking that enabled us to site the four new hospitals in Florida without a tremendous amount of in-fighting about where they were to be located. Of course, I commend you for your leadership as a part of that process. But this networking has been extremely important on almost a daily kind of basis.

Senator **GRAHAM**. What effect would you contemplate having on your district's ability to network, coordinate, and do strategic planning if the reorganization plan, as submitted, were to be put into effect?

Mr. **Randall.** I'm hoping that we can be of some help, if it is put into effect as now contemplated. We already—the five medical center directors in Florida—have met. We have decided to function informally as a consortium and to continue to carry out some of the function in much the same manner as we have in the past on an informal basis rather than a structured, defined, organizational level. We think we can provide a lot of help and a lot of service to the regional office, the veterans' organizations of Florida, to the congressional delegation, to all the constituencies in Florida if we function as an informal collegial group. We don't need a formal box to put us in on the organization chart to do that.

But I think it is important that we do it, and I think that we can continue to do it without needing any extra people or extra funds.

Senator **Graham.** Mr. Chairman, am I correct that we are going to have some further hearings on the reorganization proposal?

Chairman **Cranston.** Not necessarily. We haven't actually planned for that. We could get into it on March 22 when the Secretary will be up. I'd be glad to talk with you about how we go on that.

Senator **Graham.** I have some further questions, but in the interest of time I will hold those for the subsequent hearing.

Chairman **Cranston.** Fine. Thanks.

I just have three more questions to pose to you. I think you can more or less answer this one with a yes or a no.

Mr. **Randall.** Is that leading the witness, Mr. Chairman? [Laughter.]

Chairman **Cranston.** There are two parts. Do you believe that the functions performed at the district level—this is prereorganization—were needed and can be performed as effectively at the regional level or can be eliminated?

Mr. **Randall.** Yes, they were needed; no, they can't be eliminated and they can't be performed as effectively at the regional level. However, in my——

Chairman **Cranston.** Can be or cannot be?

Mr. **Randall.** Cannot be. But I think we can bridge the gap with an informal kind of organization, as I suggested in responding to Senator Graham.

Chairman **Cranston.** Joe, you are also a district director, so let me ask you that question.

Mr. **Moore.** I think that they can be performed at the regional level.

Chairman **Cranston.** They can be, you say?

Mr. **Moore.** Yes.

Chairman **Cranston.** And were necessary?

Mr. **Moore.** Were necessary.

Chairman **Cranston.** Stanley or Barb, anything to add to that?

Ms. **Gallagher.** Nothing to add.

Chairman **Cranston.** This next one can be a straight yes or no, in the interest of time.

Are you providing inpatient and outpatient care to all mandatory patients.

Mr. **Moore.** Yes.

Mr. **Randall.** Yes.

Dr. **Geyer.** Yes.

Ms. **Gallagher**. Yes.

Chairman **Cranston**. Finally—again, yes or no—we'll start with you, Barbara: are you treating any Bs and Cs for either inpatient or outpatient care?

Ms. **Gallagher**. We are treating a few. We have about 4 percent Bs and Cs.

Chairman **Cranston**. Of inpatient or outpatient?

Ms. **Gallagher**. Outpatient. I'm sorry. Four percent outpatient.

Chairman **Cranston**. No inpatient?

Ms. **Gallagher**. No inpatient.

Chairman **Cranston**. Stanley.

Dr. **Geyer**. We have about 1 percent B and 1 percent C in both inpatient and outpatient.

Chairman **Cranston**. Joe.

Mr. **Moore**. I would say about 2 percent, both inpatient and outpatient.

Mr. **Randall**. Yes, we are treating a very few.

Chairman **Cranston**. Thank you very much. That concludes the questions I am going to put to you. I appreciate your coming and your frank testimony. Thank you very, very much.

We now go to the next panel of VA field witnesses. This panel is composed of five regional office directors. I'd like to welcome Henry Gresham from Manchester, NH; Stephen Lemons from Waco, TX; James Maye from Los Angeles, CA—Jim, a special welcome to you; Jack McReynolds from Denver, CO; and Ralph E. Smith from Roanoke, VA.

As in the case of VA health care field witnesses, you were not asked to provide prepared statements; instead, you have been asked to be here just to respond to questions. Generally my questions will be directed to all of you unless I indicate otherwise, as I did with the last panel.

Again, I want to express my thanks to each of you for traveling to be with us. Thanks for coming all the way from California, Jim. We very much appreciate the contribution each of you is making to our Nation's veterans.

I will not reiterate the comments I made at the outset of the last panel's testimony. I know you were here. I know what I said to your field medical colleagues, of course, applies to you.

I now ask you to rise and raise your right hand so you can be sworn in.

Do you swear or affirm that the testimony you will give to this committee at this hearing today, and any written answers or statements you provide to this committee in connection with this hearing will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

TESTIMONY OF HENRY W. GRESHAM, DIRECTOR, VA REGIONAL OFFICE, MANCHESTER, NH; STEPHEN L. LEMONS, DIRECTOR, VA REGIONAL OFFICE, WACO, TX; JAMES MAYE, DIRECTOR, VA REGIONAL OFFICE, LOS ANGELES, CA; JACK McREYNOLDS, DIRECTOR, VA REGIONAL OFFICE, DENVER, CO; AND RALPH E. SMITH, DIRECTOR, VA REGIONAL OFFICE, ROANOKE, VA

Chairman CRANSTON. Now to the questions. As a lead-in, have you been instructed by Central Office as to the testimony you are to provide here this morning? I'm going to ask each of you. Ralph.

Mr. SMITH. I have not been coached or asked to speak anything other than the truth.

Chairman CRANSTON. Anyone different from that?

[Chorus of noes.]

Chairman CRANSTON. If you at any time become concerned, as I said to the other panel, about retaliation because of whatever testimony you are going to give, I hope you won't hesitate to contact me directly.

To begin with, would you each please State the number of years of experience you have had with VA and generally where you have served. Also, in very general terms—we'll get specific shortly—please characterize the current funding and resource situation of your facility, just very, very briefly.

We'll start with you, Ralph.

Mr. SMITH. Mr. Chairman, I have 31 years experience in the VA. I started as an adjudicator in Pittsburgh, went into ADP, was assistant director at three different data processing centers, led the target development effort, and in the last 11 years I have been director of the regional office in Cleveland and/or Roanoke, VA.

Chairman CRANSTON. What is the general funding situation?

Mr. SMITH. The general funding situation this year, 1990, as well as what we understand will come in 1991, as far as Roanoke is concerned, I am quite happy with it.

Chairman CRANSTON. Jack.

Mr. McREYNOLDS. I have 25 years of experience with the VA in several different regional offices. I have been the director at Denver, CO for approximately 2 years now.

As far as my funding situation, I think this current fiscal year certainly has been better than it has in the past. Obviously, I know there is always a need for additional funds. I think any one of us would say that. But it has been a relief this year, and, hopefully, for 1991 we can continue at that level, if not a little bit more.

Chairman CRANSTON. Jim.

Mr. MAYE. I have 12 years of working for the agency, and I have about 6 other years of direct association in one way or another with the agency. I have worked in four regional offices, and 4 years in Central Office working in the Studies and Analysis Service.

As far as budget for 1990, I would say my budget is fully adequate.

Chairman CRANSTON. Steve.

Mr. LEMONS. Thank you, Mr. Chairman. I'm Steve Lemons. I have 17 years with the Government. I have been the director of the Waco regional office for 6 years. Prior to that I was in Central Office as the director of the Vocational Rehabilitation and Counseling Service. Prior to that I was a counseling psychologist in Columbia and Milwaukee.

The funding situation currently is very adequate in Waco. After a precipitous decline over the last 9 years, this is the first increase in funding. While I am satisfied with that, Mr. Chairman, I am apprehensive as to its continuation in comparison to the workload we face in our area. I would also like to add that in the Waco regional office jurisdiction we cover the northern half of the State of Texas, with Houston covering Houston and San Antonio and the Rio Grande Valley.

Chairman **Cranston**. Henry.

Mr. **Gresham**. Mr. Chairman, I have approximately 20 years experience with the Department of Veterans Affairs, previously the Veterans' Administration. I have served in three different field facilities and VA Central Office in Washington.

With respect to our current funding situation, it is adequate.

Chairman **Cranston**. Thank you very much. Now let me go to this: what is your experience in the area of backlogged claims and long processing delays? Specifically, where does each of your offices stand in terms of timeliness with regard to compensation and pension claims? Let me start with you, Ralph.

Mr. **Smith**. I believe in this past year we have seen improvement. Normally what we have is a work-on-hand report that we have prepared for us each Monday morning.

I'd say against a year ago, today's situation is much improved—perhaps 20 or 30 percent. That does not necessarily mean that our timeliness is much better, however, because I think what has happened in the claims processing area is that the claims processing situation itself is much more difficult. We have a lot more things to do to establish the viability of the claim. As a consequence, there are more stages and perhaps more steps, and we are lengthening the period of time that it takes from the time of the initial application to the time when the issue is resolved and the check is in the mail or the denial is given.

Just recently, for example, now we have to produce a much more detailed letter to the claimant when we deny an issue. That's part of the due process growth. This is going to cause the need for additional people either in adjudication and/or in a typing pool, depending how that work is handled.

All in all, I would say that the situation from a year or 2 years ago when we were on a steep decline to this year when Roanoke sees an upsurge in staffing, I'm quite encouraged that the allocation process, at least, insofar as we are concerned in Virginia, has worked better for us. Our situation is not at all bad.

Chairman **Cranston**. Jack.

Mr. **McReynolds**. My situation is not as rosy as Ralph's. My pending backlog right now is 6.1 days. That would probably translate into 8,000 claims.

Our timeliness on C&Ps can average anywhere from 35 days to 6 months. I would imagine it to be closer to the latter, overall.

The impact that Ralph referenced, the additional time spent to advise a claimant of the reason for the denial, the evidence used, etc., is certainly going to impact on our technicians, as well as clerical help. That is going to put an additional demand either for more people, or this could drag out the timeliness considerably more than it is. That situation hopefully we can remedy in some fashion, but it will require some additional staffing for that reason.

Chairman **Cranston**. Thank you. Jim.

Mr. **Maye**. Yes, sir. I think I'd pretty much reflect the same thing. The workloads are declining. In the past couple of years we have seen a significant decline from approximately 15,000 cases pending down now just to under 12,000 cases pending. The timeliness has not shown equal improvement. We are showing some minor improvement, but not in the same vein.

I think, as stated by Ralph and by Jack, primarily the complexity of the case is one way we are making things a little bit more difficult. But overall, I am generally pleased with the way we are going. We could always, of course, do much better.

Chairman **Cranston**. Steve.

Mr. **Lemons**. Mr. Chairman, I can't be optimistic in this regard. The loan guaranty situation in the Waco jurisdiction and in the Texas market has been so great that the demands in the office to meet the workload in that area necessitated shifting resources from other divisions into the loan guaranty division. As a result, our timeliness has continued to deteriorate and we are at a low point at this particular period.

However, we, with the fiscal year 1990 budget, are adding adjudicators back into the adjudication division, and we are hopeful that if we can continue that kind of resource mix in the following year we will be able to reverse our timeliness decline.

Chairman **Cranston**. Henry.

Mr. **Gresham**. Mr. Chairman, in the Manchester regional office, for processing of CP&E claims, I think the timeliness is excellent. Because I am representing a relatively small office, the adjudication officer and I are able to give a fair amount of personal attention to the older cases. I believe I can say with honesty that when we look at the really old cases that we have on hand, the reason for the lack of timeliness on them is not because of a lack of resources within my office; it is almost invariably for a reason that is beyond my direct control and could not be solved by adding additional employees to my office.

Chairman **Cranston**. I think the next question can be answered with a yes or no and then two figures. Let me start this time with you, Henry.

Do you need additional personnel in order to meet timeliness standards in fiscal year 1991? If so, what FTEE and what amount of dollars?

Mr. **Gresham**. Mr. Chairman, I would answer in the negative. I do not.

Mr. **Lemons**. Similarly, Mr. Chairman, if we can maintain what I have been provided in fiscal year 1990, I don't believe I will need additional.

Chairman **Cranston**. Jim.

Mr. **Maye**. I would concur. I don't believe I need additional resources.

Mr. **McReynolds**. I believe that I will need at least three additional FTEE in adjudication to accommodate the changes in the processes themselves.

Chairman CRANSTON. What would that mean in dollars?

Mr. MCREYNOLDS. That would be roughly $100,000 in additional funding.

Chairman CRANSTON. Ralph.

Mr. SMITH. I would say we have additional needs, Mr. Chairman. I think being in a unique location where we are, I think we are seeing an increase in the number of defaults and foreclosures in the loan guaranty program. That's going to require additional servicing and additional work to dispose of property which we are almost sure to acquire.

I think if we are going to bring the telephone unit up to the level of less than 10 percent lost call rate we are going to need two or three VBCs in that area.

Now, one of the problems we have is we are always moving people around according to the need. I think what we have seen and what the Independent Budget shows, as well, is that we have mostly lost our flexibility. We don't have enough left over in any area really to take care of the ups and downs in unplanned workloads.

But I would say, in answer to your question, we would need additional staffing in order to handle the telephone workload and the increasing workloads which we see coming in loan guaranty, and probably a couple of additional FTEE for the vocational rehabilitation program. So we do need additional resources.

Chairman CRANSTON. Thank you.

Again, starting with you, Henry, what are the principal factors which affect the vocational rehabilitation and counseling workload and is that workload at your regional office increasing, decreasing, or remaining constant?

Mr. GRESHAM. Mr. Chairman, at my regional office I would say that workload is remaining relatively constant. Again, the timeliness that we are able to give in vocational rehabilitation is excellent. I think the factor that enables us to have good timeliness in that area is that I have a very stable work force. I happen to have three counseling psychologists who have a great deal of experience, who have been there for a long time, and are doing an excellent job of it.

Chairman CRANSTON. Steve.

Mr. LEMONS. Mr. Chairman, our vocational rehabilitation activity is the largest in the country, and it is continuing to grow. In the last 3 years we have gone up from 1,400 new applications to 1,800 new applications. I would characterize this as a number of reasons: one is the termination of the GI bill; two, the serious unemployment situation in the Texas economy. This is an area where we are taxing existing resources and committing additional resources.

Chairman CRANSTON. Jim.

Mr. MAYE. The workload for southern California, the Los Angeles area, is growing. We are compensating for it by adding additional personnel that we are taking from other sources where workloads are diminishing. Our workload in loan guaranty is diminishing, so I am simply redirecting those resources.

Chairman CRANSTON. Jack.

Mr. MCREYNOLDS. I can't say my workload is diminishing. I think the problem with the economy of Wyoming and Colorado, that we have responsibility for in vocational rehabilitation and loan guaranty is likely to continue to increase. And we are driven by an energy-related economy in both States. It will be a long time before that is going to turn around. I think the end of chapter 34 will impact on chapter 31 vocational rehabilitation counseling.

Chairman **Cranston**. Ralph.

Mr. **Smith**. Our vocational rehabilitation caseload has gone up in 2 years from 726 active trainees to 1,085. We have one of the larger vocational rehabilitation caseloads. So you can see there has been an increase there of about 50 percent over 2 years.

We have added staff. We recognize the problem. But we still have inordinate caseloads for most of our professionals. We would need to add at least one counseling psychologist and one vocational rehabilitation specialist, and maybe two.

Chairman **Cranston**. I want to say at this point before we proceed that, unfortunately, my schedule got changed. I was planning to be here until 1 p.m., but I have to leave now to catch a plane due to a change in my schedule. I guess we should have started at 7 a.m. instead of 8 a.m. The staff will carry on and propound questions that I would propound were I able to stay. I apologize to the witnesses that I will not hear firsthand, but I will know what you testified to.

I thank the people who stepped aside from the other budget discussion. We will still give you your opportunity.

I'm sorry that I will not hear all the witnesses. I thank everybody for your great cooperation and your patience through this long session.

Jon Steinberg will now carry on.

Mr. **Steinberg**. I think we were focusing on VR&C timeliness standards for fiscal year 1991. To followup on that, and start with Ralph, specifically do you need additional personnel in order to meet VR&C timeliness standards in fiscal year 1991?

Mr. **Smith**. A one-word answer is yes.

Mr. **Steinberg**. Jack.

Mr. **McReynolds**. Yes.

Mr. **Steinberg**. Jim.

Mr. **Maye**. Within the VR&C that would be affirmative. But I am redirecting some of our resources, and I don't believe I will need overall additional resources.

Mr. **Steinberg**. Steve.

Mr. **Lemons**. I will definitely need to add. In fact, I am recruiting right now and will need additional resources over and above that which I have currently committed.

Mr. **Steinberg**. Henry.

Mr. **Gresham**. Mr. Steinberg, I looked carefully at these figures before I came to the hearing. I am going to be out of step with my colleagues. We are meeting the standards and will not need additional resources to continue that.

Mr. **Steinberg**. It comes as no surprise that we don't have a monolithic system and that there are variations, and that's one of the things that this sort of hearing helps us develop. So we just want the facts.

In that regard, what projections are you making in terms of demand for VR&C counseling if we do have a substantial gearing down of the Armed Forces, and therefore a substantial increase of veterans, including some service-connected disabled veterans, who would be leaving the service? We will start with Henry. Have you given any thought to that? Or do you have any projections?

Mr. Gresham. Sir, we have given it some thought, but I must honestly say we don't have any projections. It is very difficult for us to gauge what the impact of that will be locally.

Mr. Steinberg. Steve.

Mr. Lemons. We have absolutely given thought to it, and I have extreme concern about that since one of the projected announced reductions is a 12,000-person reduction in Fort Hood by removing a division from U.S. Army—that is in my area of jurisdiction—coupled with what I continue to see as a depressed economy. I believe that we will have a continuing adverse impact. There will be a growth in that workload in my jurisdiction.

Mr. Steinberg. Jim.

Mr. Maye. It is an issue we have discussed often, but, like my colleagues, I have no way of giving any accurate forecast of what the impact will be or how we are going to deal with it.

Mr. Steinberg. Jack.

Mr. McReynolds. We anticipate quite a large impact in Colorado because of the multiple bases there. We do not have sufficient data to make any projections right now. It is of concern to us.

Mr. Steinberg. Ralph.

Mr. Smith. I share that concern and have voiced it with Central Office personnel with whom I have talked. I am concerned especially because of the large Navy installation we have in Norfolk.

But as far as any solid planning yet on what the impact may be, I can't say that there is any forthcoming right now.

Mr. Steinberg. If you develop more information on this in the course of the year, we would hope that you would followup and let us know what your projections are.

Can you tell us—and we'll start with Jim and radiate out—what is your VR&C no-show rate and its impact on your ability to provide timely service?

Mr. Maye. Well, our show rate, we have 68 percent of the people we schedule right now showing. We have been able to have a significant increase in that by out-basing our counseling psychologists. It was running approximately 50 percent, so we have had an 18 percent increase by being more accessible.

Mr. Steinberg. Steve.

Mr. Lemons. We have a 23 percent rate of rescheduling cases, and that does factor into the average days to obtain a counseling appointment.

Mr. Steinberg. Henry.

Mr. Gresham. Sir, I don't have an exact figure to give you. I would like to comment, though, that we were able to put an additional clerk in that division a couple of years ago, and one of her specific responsibilities is to call veterans just prior to their scheduled appointment. That has helped us keep that to a manageable level.

Mr. Steinberg. If you could provide that figure for us for the record; we may be submitting some written questions and you will have a chance to respond in that process. Please provide that figure. Any of you that want to supplement any of your responses, please do so.

[Subsequently, Mr. Gresham furnished the following information:]

DEPARTMENT OF VETERANS AFFAIRS REGIONAL OFFICE—MANCHESTER, NH

["No Show" Rate for the Vocational Rehabilitation and Counseling Division]

	Chapters 31 and 15			All Cases		
	Appointment established	Appointment realized	Percent no show	Appointment established	Appointment realized	Percent no show
1st quarter 1990	295	183	38.0	334	203	39.2
4th quarter 1989	375	232	38.1	400	238	40.5
3d quarter 1989	358	243	32.1	380	255	32.9
2d quarter 1989	359	212	40.9	399	239	40.1
1st quarter 1989	356	215	39.6	403	236	41.4
Total	1,743	1,085	37.8	1,916	1,171	38.9

NOTE—The term "no show," as used in this data, includes both instances where a veteran or other eligible person simply failed to show for a scheduled appointment, as well as instances where a veteran or other eligible person canceled and rescheduled. All data was extracted from the Veterans Benefits Administratin's Automated Management Information System (AMIS).

Mr. STEINBERG. Ralph.

Mr. SMITH. I don't believe I have the no-show rate with me, but we did the same thing that Henry mentioned. We added a step in there to check at the last minute to keep that no-show rate down. As I recall, it is somewhere around 20 to 25 percent.

Mr. STEINBERG. Jack.

Mr. MCREYNOLDS. We are averaging about a 30 percent no-show rate.

Mr. STEINBERG. And does that have an impact on your ability to provide timely service?

Mr. MCREYNOLDS. Sure it does.

Mr. STEINBERG. The next question is: do you have any suggestions for reducing this? I think you have implicitly or explicitly covered some of the things you have done, Jim, in terms of this approach and then the two of you that have added someone to sort of monitor and make sure that people are reminded. Are there any other suggestions that you have in order to deal with the no-show situation?

Mr. MCREYNOLDS. I'll respond by saying I don't know whether we can really get that down that much more. We do provide motivational phone calls, rescheduling of appointments, etc., but we have always run anywhere from 25 to 35 percent. It will just fluctuate.

Mr. STEINBERG. Steve, the next question we want to start with you. What are some of the effects of a lag time between a veteran's application for vocational rehabilitation and his or her initial appointment with a counseling psychologist? What effect does that lag time have on the success of the subsequent program?

Mr. LEMONS. Of the lag time that occurs, part of it occurs in the adjudication division between the time either a veteran applies and may not have a rating or may not have basic eligibility or some critical element in determining his remaining entitlement.

There is no doubt that the lag time between the time of an application and the time of an appointment would have an affect on the rehabilitation; however, I would feel that the adequacy of the outreach to people to ensure that they actually file the application may be a more significant factor than the delay in getting in to actually see a counselor. If we are making that outreach contact and we can get that down to 30 to 45 days for actually coming in and being seen by a counselor, I think that would be in an acceptable area. We are not down there yet.

Mr. STEINBERG. Do any of you have any comments on this issue? Henry.

Mr. GRESHAM. Mr. Steinberg, again, that's a figure I looked at before I came here. We have measured our time from the time we get the application when it first hits our adjudication division until we are able to see the veteran. We estimate that right now at about 45 calendar days. We feel that's acceptable timeliness and really haven't been having any great difficulty in that area.

Mr. STEINBERG. You said you are getting yours down into the 30-day vicinity, Steve.

Mr. LEMONS. That's a goal I'm shooting for.

Mr. STEINBERG. Right.

Mr. LEMONS. Right now I am at 72 days. With the addition of two counseling psychologists, I hope this fiscal year to bring that down to about 50.

Mr. STEINBERG. Jim, what would your current delay be?

Mr. MAYE. From the time the person applies in adjudication we are running approximately 130 days. It is quite a significant amount of time. The amount of time once they are determined eligible until we can get them is 44 days, I believe.

Mr. STEINBERG. So it is 130 days from contact to first appointment? Do I understand you correctly?

Mr. MAYE. Well, not quite. It is approximately 130 days from the time they apply for VA benefits. At that point they have yet to be determined eligible for compensation. They have to go through that determination within adjudication.

Mr. STEINBERG. Once determined eligible, then it is 42 days?

Mr. MAYE. It is about—right now the last number I saw was 44 days.

Mr. STEINBERG. And was that the period that you were each giving, Henry, from the eligibility determination to the first——

Mr. GRESHAM. No, sir.

Mr. STEINBERG. From initial application?

Mr. GRESHAM. Yes, sir. That's correct. For me, once eligibility is determined and the application goes to our vocational rehabilitation division, then I would give you a figure of about 26 calendar days to see the veteran.

Mr. STEINBERG. And Steve, you——

Mr. LEMONS. The 50 days I was talking about were once it is in the VR&C division to the time they actually come in for an appointment.

Mr. STEINBERG. Which means the person has been deemed eligible?

Mr. LEMONS. Right.

Mr. STEINBERG. Has been determined eligible?

Mr. LEMONS. That's right.

Mr. STEINBERG. So your 50 days compares to——

Mr. **Lemons**. Corresponds to Jim's 44 days.

Mr. **Maye**. And mine is 44 work days. The calendar days would be a few more. I would assume that's somewhere around 55 or so calendar days.

Mr. **Steinberg**. OK. We have to be very careful here.

Mr. **McReynolds**. Really, I think our time is 77 days, but that is from the date of application to the date of the initial appointment.

Mr. **Steinberg**. So you don't have one beginning with the determination of eligibility?

Mr. **McReynolds**. No, I don't.

Mr. **Steinberg**. Is there no uniform criteria that you are supposed to keep and report back to Central Office on this issue? I see some nods yes and some negatives.

Mr. **Lemons**. The uniform work count is from the date the application is received in the regional office until the date the person actually comes in and is seen by a counseling psychologist.

Mr. **Steinberg**. Is it in work days or calendar days?

Mr. **Lemons**. Calendar days.

Mr. **Steinberg**. And yours was 70?

Mr. **McReynolds**. Seventy-seven days was the last number I said.

Mr. **Steinberg**. Ralph, how about yours?

Mr. **Smith**. I have two different numbers. For those who are seen at Roanoke the number is, I think, 46 days. For those that are seen at Hampton, it has been 94 days, I think.

Mr. **Steinberg**. Jack, Senator Cranston has long been pressing for additional FTE for loan servicing and property management, as indeed has this committee, in general, and has been the House Committee on Veterans' Affairs. As you know, funds were appropriated in fiscal year 1989 to increase servicing. So all four of the congressional committees involved—appropriations and authorizing—are very supportive of this effort. The report of the Houston pilot project, with which we believe you are familiar, indicated an average net savings to VA of about $1 million for each of the 10 FTE added in that project. In other words, a total savings of about $10 million. We understand that you visited the Houston regional office and looked at its pilot project. Could you explain briefly your opinion of this program and whether you think it could apply and should be applied in your and other regional offices?

Mr. **McReynolds**. I certainly do. At the time I visited Houston they had modified it somewhat. They did have a different schedule in place, but it was very effective.

I certainly incorporated some of those ideas that I picked up when I was down in Houston, and we shifted personnel from the upfront end of the business to servicing.

I finally got 43 people in servicing.

Mr. **Steinberg**. How many? I'm sorry.

Mr. **McReynolds**. Forty-three FTE devoted to loan servicing claims.

We did reduce our pending defaults from approximately 9,500 to 7,400.

Mr. **Steinberg**. So that's about a 25 percent or better reduction?

Mr. **McReynolds**. Yes. We were inundated.

Mr. **Steinberg**. Steve, I'm sure you know about the Houston experiment, and probably looked rather enviously upon it.

Mr. LEMONS. Salivating constantly, sir.

Mr. STEINBERG. Do you believe that would be applicable in your regional office and would produce similar kinds of benefits?

Mr. LEMONS. Absolutely. We have been so inundated with notices of default and notices of intentions to foreclose that we cannot even keep up with the coding actions necessary to do that. We have some 9,000 cases that are pending foreclosure. We are, at the moment, attempting to gear up. One of the positives of the yo-yo effect of the budget this year was that we were provided additional staffing, but, as a result of sequestration, did not gear up. We are, at the moment, attempting to supplement in our loan service and claims section to the tune of 12 to 15 bodies, depending on how quick we can recruit them and how quick we can get them on. We anticipate having an effect on the cure ratio as well as on the reduction in the foreclosure activity, itself.

Mr. STEINBERG. Generally, starting now with Henry, do you believe that you could use more FTE effectively and cost-effectively in your home loan servicing and property management activities? If so, do you have any idea of what kind of an increase you would need?

Mr. GRESHAM. Mr. Steinberg, I'm in a rather unique situation in Manchester because of this impending consolidation. I have, in fact, doubled my staff in that area, even though I may not be able to justify that at the moment. But I am anticipating the consolidation.

Also, our economic condition up there is so far different from that that some of my colleagues are experiencing that really I don't need any additional resources and I'm not having a significant problem in that area.

Mr. STEINBERG. Steve, if you get the people on board that you have calling for now would that do it, or do you need more?

Mr. LEMONS. I believe that will allow me to do that. My concern is whether or not that will be recognized in the 1991 budget and continued on—especially at the level that I'm staffing now, taking advantage of, in essence, a two for one deal. By not getting them on until April I'm getting two FTEE on duty—that's one FTEE equivalent. I'm concerned that come October that I don't get reduced back to having to annualize that. I think I will need every bit of the staffing that I am putting on.

Mr. STEINBERG. Jim.

Mr. MAYE. Well, right now I have 47 people authorized for loan servicing claims. My default cure rate is a little better than 86 percent. So we have put a lot of energy and effort into it, and it has been quite successful. Could it be improved? Possibly. What would it take and what degree of improvement I could acquire? I really couldn't give you a real, viable answer.

Mr. STEINBERG. Jack, do you have some ideas on that?

Mr. MCREYNOLDS. I think I am adequately staffed in servicing claims right now, evidenced by the fact we were able to reduce that tremendous backlog of defaults pending.

Now, you get to a point where you are going to need every one of those bodies to do an adequate job of servicing. I certainly could not anticipate removing anybody from there, but as time goes along and we monitor it might be possible to even add staff. But I can shift within that division.

Mr. **Steinberg**. Ralph.

Mr. **Smith**. I would have to answer that with a maybe, because, again, I'm very concerned about the peace dividend in the Tidewater.

Right now we have six or seven trainees in loan guaranty, and they are recent acquires. So that when they are trained, I think if we had a static workload we would probably be adequate. But I'm afraid that workload, as I mentioned in answer to one of the earlier questions, is going to grow. If that happens, of course, we will need commensurate resources to handle it.

Mr. **Steinberg**. We'll start this with Steve. What has been your experience with any FTE savings from the loan production system and how quickly such savings are realized?

Mr. **Lemons**. The savings as a result of the loan production system, I don't have a firm figure on that. I can tell you, though, that we have not implemented that system in Waco to the fullest level it is anticipated. The code sheet elimination has been very effective and has been very effectively handled. The other anticipated automation activities in loan guaranty will have significant savings that have not yet been realized, in any way, when you're talking the volume of work we're talking about——

Mr. **Steinberg**. Coming down the road.

Mr. **Lemons**. Down the road further. Right.

Mr. **Steinberg**. Henry.

Mr. **Gresham**. Sir, none of this loan guaranty automation has occurred at my station yet. I'm expecting it.

Mr. **Steinberg**. So we'll have to wait and see. Ralph.

Mr. **Smith**. We have installed code sheet elimination and it is working very well. But in light of increasing workloads, we couldn't identify any FTE savings. It has just been the resources redirected to other things that have to be done.

Mr. **Steinberg**. Do you see those savings down the road?

Mr. **Smith**. Quite frankly, it will depend pretty much on the economy. If we would have a leveling out of the work—for example, I think I did mention foreclosures have doubled in the past 3 years in our area. So any savings we get are mostly illusory because we have to put additional resources to work.

Mr. **Steinberg**. Jack.

Mr. **McReynolds**. I see it as simply another tool. I only have the code sheet elimination portion of the loan production system. I really have not identified any way that I see a savings to date. It simply is a different way of performing a task. To be sure, it is much more efficient, but those savings that we do realize are poured right back into the servicing effort.

Mr. **Steinberg**. Jim.

Mr. **Maye**. Basically it is the same. I have only implemented the code sheet elimination. I cannot equate any particular FTEE savings to it specifically.

Mr. **Steinberg**. Now, applying this notion we have just been talking about more generally, you have witnessed the impact of ADP modernization since 1985 and the changes it has brought about in the way services are provided. What is your view of the relationship between ADP modernization and staffing levels, including FTE needs, during the development and implementation of new ADP equipment and software, and thereafter when the ADP is in place? We'll start with Ralph on that.

Mr. **Smith.** I think the modernization effort is well conceived. I like what I see.

Mr. **Steinberg.** We want to focus on the relationship between FTE and modernization.

Mr. **Smith.** The relationship for that system to savings?

Mr. **Steinberg.** Right. FTE savings. And particularly during the stages of implementation and development versus the actual ADP being fully in place.

Mr. **Smith.** Yes. Quite frankly, I think I don't identify with the kind of savings that ADP seemingly has to acquire in order to install. As I said in my resume earlier on, in answer to the Senator's question, I have been around ADP ever since I was quite a young fellow. Most of the time what happens is the Congress and the administration—or whatever we call it now—seems to require of people greater efforts to use data processing—at least in the commercial kinds of businesses that we are in. Our laws are much more difficult. The requirements for due process are much more involved.

My answer to your question is: thank God we have the tool to do the job, but the job seems to be harder all the time and it seems to me that we are not saving anything in the long run.

Mr. **Steinberg.** Jack, what do you think about savings of FTE?

Mr. **McReynolds.** I don't identify savings during the implementation phase of ADP. Now, possibly there may be a payoff down the road. As a matter of fact, I think it puts additional demands on you. You have to have specialists. We are not fortunate enough to have those on board, so you usually have to recruit.

I think the implementation phase is costly, but it certainly is a lot better way of doing the same job.

Mr. **Steinberg.** Jim, what do you think about that relationship.

Mr. **Maye.** I would agree with Jack. One of the things that I have noted with the particular mode that we are using ADP, the Wang systems, and we are doing local development in some cases, it is actually requiring additional FTE. I am taking people from other areas that I recognize savings due to whatever and applying that FTE toward my ADP management and development, hopefully realizing further savings down the road. We have done a little bit of that with some programs that we have developed for processing veterans' inquiries. But it is a wash. I save on one end, and I'm using it somewhere else for development.

Mr. **Steinberg.** Steve.

Mr. **Lemons.** I would totally agree. The savings are not there and shouldn't be expected to be there because the needs that you have and the effectiveness of the ADP applications are such, that you identify other areas of need that occur that you didn't even know that you had. When you are dealing with a large workload and you are trying to live within constrained resources, it is the areas of oversight, followup, and things of that nature that ADP allows you to restore that you have lost when you didn't even know you were losing.

Mr. **Steinberg**. Henry, do you have any comments on this?

Mr. **Gresham**. Just briefly, sir. I believe I have experienced some savings in terms of transcription activities—maybe a minor clerical saving in that area. I would like to comment that—of course, I'm at a station that has just over 60 people—I have found it necessary to add two people full time just to run the ADP systems that we now have on station.

Mr. **Steinberg**. Moving to another area, have any of you or any of your fellow directors, as far as you are aware, ever felt pressured to reduce the number of long-distance or local lines into your station so as to reduce your monthly line charges or because you believed your staffing level was inadequate to cover all lines in a timely manner? We'll start with Ralph again.

Mr. **Smith**. Yes, I would believe I would have to respond that way.

Mr. **Steinberg**. You have felt that pressure?

Mr. **Smith**. Yes.

Mr. **Steinberg**. And have you done so?

Mr. **Smith**. Two years ago I did.

Mr. **Steinberg**. Jack.

Mr. **McReynolds**. Yes, I have done so.

Mr. **Steinberg**. Has that occurred frequently?

Mr. **McReynolds**. No. Three years ago I did reduce some lines due to budgetary pressure.

Mr. **Steinberg**. Jim.

Mr. **Maye**. I would also say yes, but that has been several years ago.

Mr. **Steinberg**. Steve.

Mr. **Lemons**. I reduced lines into the regional office in fiscal year 1987, but I would have to say that was a tradeoff in freeing up resources to enhance outreach. I took people off of phones and terminated phone lines I wasn't able to answer anyway.

Mr. **Steinberg**. Henry.

Mr. **Gresham**. I would say I haven't really felt that pressure, although a couple of years ago I did feel it necessary and advantageous to reorganize the veterans' services division in an effort to avoid having to do that.

Mr. **Steinberg**. Thank you for your very concise and responsive answers.

Henry, recently the VA looked at the issue of loan guaranty processing for the six-State New England region, as you know, and decided that the Department would be more efficient and be providing better service if all loan guaranty processing for New England were to be done from Manchester. However, the proposed staffing for the consolidated loan guaranty unit at 22 FTE is a reduction of 9 from the combined total of 31 now assigned to the loan guaranty responsibilities in the four regional offices whose functions are being consolidated.

Do you feel you will have sufficient staffing to provide adequate loan servicing, property management, and specially-adapted housing support, to name a few of the required activities of a loan guaranty program, after the consolidation with this 22 planned FTE?

Mr. **Gresham**. Sir, I believe the resources will be adequate. I base that on two reasons. First, the number 22 has now been superseded by a larger figure of 25. I have not seen the revised organizational chart, but I have been assured that 25 is now the final count. Second, I have been given some assurance that I will receive additional resources if that is what is required to make the project work.

Mr. STEINBERG. Is anybody here from the Department still?

[No response.]

Mr. STEINBERG. That's interesting, because the official proposal to the Congress in the January 22 submission I believe set the level at 22. We're delighted to hear that you may have more resources.

We'd appreciate it, if this reorganization goes ahead, if you would let us know whether or not you, in fact, receive the 25. And if you do or if you don't and there is a need for more FTE, we'd like to know about that, as well.

Mr. GRESHAM. Yes, sir.

Mr. STEINBERG. Do you feel that this 25 FTE will be enough even if there is a resurgence in the housing market in New England?

Mr. GRESHAM. I believe that it will be enough. Now, it is difficult, and it is probably not practical, to try to staff a loan guaranty division for the absolute maximum workload that we might anticipate at any time. Let me cite the current situation we are in. We have had about an 80 percent increase in workload over last year, but that represents only about a 35 percent increase over where we were 3 or 4 years ago.

I believe that, on average, this number will be sufficient. We have been able to effect a savings, primarily in the overhead.

Mr. STEINBERG. Do you feel that you will be able to handle, on a timely basis, all of the on-site inspections that are needed for the specially-adapted housing program?

Mr. GRESHAM. It is ironic that you should ask that particular question because it was our concern about the specially-adapted housing program that probably spawned the original idea to come up with some different organizational structure in New England.

Let me cite the example again of Manchester. We had six people working in loan guaranty and we had one person who had partial responsibility for the specially-adapted housing project or program. I lost that individual about 3 years ago and found myself unable to devote any resources to specially-adapted housing, so I had to call on Jim Maye, who at that time was the director in Boston, to assist me. It was that incident that actually got us started looking at the issue of how we might reorganize things to avoid that happening again in the future.

Mr. STEINBERG. But your feeling is that this is a workload spread over these States that you will be able to handle with the resources that you will have?

Mr. GRESHAM. Yes, sir, I do. Now, the geographic area, of course, is larger. But still, when we look at the geographic area compared to several other States, we really don't see the geographic problem being that great. The whole geographic area would expand to about 300 by 500 miles, which is comparable or smaller than many western States.

Mr. STEINBERG. But the concern that has been expressed in this regard is that there will be a reduction of timeliness from what it is now, not that you will be as timely as Wyoming. Can you comment on that?

Mr. GRESHAM. We just don't foresee any particular reason why timeliness should decline. If anything, it lessens my concerns about timeliness because right now in such a small division if I have one person absent on an extended illness or a vacation, that's what really causes me the significant timeliness problems. By giving me some redundancy in the different areas in loan guaranty, I think timeliness should at least remain the same, if not improve.

Mr. STEINBERG. I'm talking about timeliness through the whole area. Jim, why don't you feel free to chime in, since you know a little bit about the Boston situation.

Mr. MAYE. I feel a little peculiar about this. When I was in Boston we were down to 10 FTE working in loan guaranty. Based on the experience shared between Henry and I, I believe personally that the ability to provide specially-adapted housing will only improve for all of New England.

You are having now 25 people to draw on. Before we had little pockets of 6 people here, 10 people there. With small numbers like that it is extremely difficult to have any flexibility. I think now New England will have that flexibility.

Mr. STEINBERG. We appreciate your unpaid-for and unsolicited agreement with this proposal, and we're glad that we have the added value of your experience in Boston to enlighten us on that.

Henry, to your knowledge would your travel fund designed for the inspections of specially-adapted housing and for VA's appraisal responsibilities be fully protected against a sequestration reduction?

Mr. GRESHAM. The way you phrased the question makes it difficult for me to answer because I'm not that conversant with exactly how the sequestration process works. I will say that the preliminary indications are that I will receive the resource support that I need. I have already been given the authority to procure another Government vehicle, and, again, from my point of view that is perhaps the way I tend to look at that resource problem.

Mr. STEINBERG. To give you an idea, for example—and I suggest you ask this question of Central Office, because the answer that we received at the briefing that we were given on this was yes. You just went through a sequestration for 4 months. Let us say that this consolidation had been in effect at that time. You would have received a pro-rata reduction in your travel money. And we believe that were that to occur, it would clearly have an impact on travel for specially-adapted housing. And since there would have to be more travel out of Manchester than there would have been were the office in Boston, for example, where you are looking at a house in the Boston area, then the situation would be made worse.

The answer that Central Office gave us was that they would give you special protection in that event.

We can no longer say that sequestrations are mere threats hanging over the head of Federal programs. They now have been realized twice in 4 or 5 years, and they certainly are a reality that we have to be concerned about. So I would suggest that you may want to ask that question and get those assurances.

Chris, I have a couple more questions and then I will be yielding to you. This is an area where perhaps you should be down there because you are as well equipped as these gentlemen are to answer these questions, at least based on something that may have occurred 5 or 6 years ago, if not today.

Mr. YODER. I am not now certain that I am not 5 years out of date.

Mr. STEINBERG. Better equipped to ask them, then.

What do you anticipate will be the effect on workload and staffing at each of your offices of the new Public Law 101-237 requirement, implemented by a circular on February 1 that one of you alluded to, that VA provide certain detailed notices and information to unsuccessful benefit claimants?

Mr. MCREYNOLDS. It is going to impact. We had a discussion just sitting around trying to figure what the impact would be. I have no study or number on it, but I think it will be significant when you consider that, for each letter, rather than simply a form letter with an address on it with certain information filled in on the blank going to a typing pool where they can reproduce, we're now talking about an individually-composed letter outlining what evidence was considered and the reason for the denial.

I don't disagree with the system or with the law. I think it is the right direction to go.

Mr. STEINBERG. But you don't have any estimate at this time of what it would take?

Mr. MCREYNOLDS. For resources, no.

Mr. STEINBERG. Isn't it going to take more?

Mr. MCREYNOLDS. It is going to take more.

Mr. STEINBERG. Ralph, what about you?

Mr. SMITH. In discussions with my adjudication officer before coming here, we guessed that we would probably need two additional adjudicators in the staff there. We have 28 or 29, and we'd need 2 more.

Mr. STEINBERG. How about in equipment?

Mr. SMITH. In equipment we are pretty well fixed because of our unique development work in a couple of ADP areas. I don't think we would need additional equipment.

Mr. STEINBERG. Jim.

Mr. MAYE. I had my adjudication officer take a quick survey, and he reported back to me that it takes about 30 percent more time to prepare that notification of denial.

Mr. STEINBERG. So you are going to have a 30-percent slowdown in processing, or you are going to have to add people to keep up.

Mr. MAYE. Initially it is 30 percent. Now, as our people become more proficient I would expect it to decline some. But I think it is obviously going to be a significant amount of time delay in the preparation of the letter. Now, whether that is going to finally translate into a requirement for additional people, I'm going to have to wait and see. I just don't know yet.

Mr. STEINBERG. How about for equipment?

Mr. MAYE. I probably have to have some additional equipment.

Mr. STEINBERG. Steve.

Mr. LEMONS. I don't have an estimate for you, but I can tell you that it will be a significant slowdown. I would argue forcefully for full support of modernization initiatives from VBA because that will be the difference in how significant the adverse impact will be on staffing.

Mr. STEINBERG. You certainly have our full support, and, as I think you are aware, have had it for quite some time. This committee has recommended substantial increases over the budget requests for ADP, and quite possibly will do so again this year.

Henry.

Mr. GRESHAM. Well, sir, I don't have a specific estimate of what the impact might be, although I have begun to notice an increase in the amount of work that we have in central transcription and I could easily foresee possibly having to add some more resources in that area—either another person and/or additional equipment.

Mr. STEINBERG. For your information, we have received informal indications from VA—although they are not yet hard figures, and we have asked them to try to harden them—that they need as many as 145 additional FTE nationwide, which translates down to something like 2.5 or 2.75 per office, consistent with what you are saying, and up to $2 million in additional equipment costs. That's very sketchy and rough information, but I think that you might like to know that.

Chris, I have a couple of more questions, but I'd like to yield to you at this point.

Chris Yoder is known I think to many of you and is the minority professional staff member who specializes in the benefits area, among other areas.

Chris.

Mr. YODER. Thank you, Jon.

I would like to adopt pretty much the same format of asking each of you to comment individually.

The first thing I noted in looking at the witness list is the complete range of size of regional offices that are represented here, from very large to medium-sized to very small. I would like each of your opinions as to the optimum size of a regional office—in terms of workload and FTEE, not geography—is and whether or not your office is in that range, larger, or smaller. I'll start with Henry.

Mr. GRESHAM. Yes, sir. I believe I have an opinion on that. It is not scientifically developed. I believe my regional office at 60 is well below optimum. Perhaps some of the larger offices are above that. I would say somewhere in the 250 to 350 range is probably close to ideal.

Mr. LEMONS. I have not formulated a firm opinion on that. Part of the reason that I had difficulty with that question is because of the distinct differences between geographical locations, the veteran population, population mix, economic factors that affect office operations, as well as benefits demand and benefits delivery. My office, at one time, was 535 FTEE. We are down to 385 and hope to go back around 405 to 410. If I get much over 400, I'm going to be a little nervous about how to manage that size of facility.

Mr. MAYE. I think Steve is correct. I think there are so many factors that enter into it that determining an optimal size station really is going to be greatly controlled by other circumstances under which you are working. I have worked in stations as small as 170 people, and we now have just under 500.

Personally, the station with 500 people gives me a great deal more flexibility, but I can't necessarily relate that to the numbers of people. We are also a MEPPS station, and that affords me additional latitudes to manage. So I would be very reluctant to come out and say this is an ideal size. I just don't think that you can do that with a hard number.

Mr. McREYNOLDS. I think it depends on the mix of the division. We are at about 320 right now. I think that might be the ideal size if all the functions were comparatively efficient. By that I mean there was a study done some years ago, I think, that indicated that the ideal size of an adjudication division was probably somewhere between 80 and 120 people. For scales of efficiency, you had better control. If you got past that point, then it would decline. If you were lower than that, it would decline also—like a bell curve.

But I think I am a little bit out of balance. I've got about 80 people in adjudication, which is usually the largest division; yet, I've got about 105 in loan guaranty. So it is a different mix.

Mr. SMITH. I have rather strong convictions that a station of about 300 would be an ideal size station. The reason I say that is because I have served in a lot of places, and I think the 300 size operation is generally going to give you good recruiting, good retention, good training, span of control is about right, and I think all in all you can get to know everybody. I think the VA is sort of known for that—to know our people and to be able to relate to them and their problems.

Recently some of our people have been talking about burnout in the adjudication area. I'm sure you have all heard that. Gee, it would be nice to be able to retrain them and to give them some relief from some of the constant pressures and so forth of their jobs. I think you can do that in a station that is larger.

And I think if you get too large—I was director in Cleveland when we had 680 people, or something like that. There were real problems with getting to know the problems intimately, getting to know the people, and things like that.

So I have strong opinions that we ought to have stations of about 300 people.

Mr. STEINBERG. The next question I'd like to ask deals with the flow of information between regional office authorization activities and rating activities and the VHS&RA side of VA—VA medical centers.

For instance, earlier someone noted that they had done a study of old cases and discovered that many of them were old for reasons beyond their control. Do you find that delay in doing comp exams or reexams contributes to delay? Is there any way to quantify that? And do you have any way of controlling it or influencing it? I'll start with Henry.

Mr. GRESHAM. Sir, I believe that is a significant problem area for us. Again, I should speak only for my own station. About two-thirds of my exams are done by the Manchester Medical Center. About one-third are done by White River Junction. We have a few that end up going to other facilities for special reasons.

In certain medical specialties we experience extremely long delays. We have very little control over this. I don't mean to cast any disparagement on the medical center. I believe people here have heard the resource problems that they have. But it is definitely a serious problem for us.

Mr. LEMONS. I would concur in that. It is so serious a problem that we have stepped up our liaison activities to the medical centers. You have to maintain top-level awareness and top-level pressure between regional offices and VHS&RA medical centers in order to ensure that this problem is addressed.

I'm also looking forward with great expectation and optimism to the installation of the AMIE computerized link between the medical centers and the regional office as soon as it has completed its field testing and appropriate procurement of software has occurred. I want to be the next one on the list.

Mr. MAYE. Well, we can't have direct control, but we do have a lot of influence. I'm just looking at my list, and I'm ranging, with the facilities that I work with, ranging from a low of 44 days to a high of about 68 days in time to get the medical exams back.

Now, one of those facilities has put, I think, an extraordinary effort in in the past 2 years. They have dropped the time from a 240-day delay down to just under 66 days. I think that's an incredible effort on their part. It does require a great deal of attention on the part of the management of the hospital. It does require the allocation of resources on their part to get it done. It takes a lot of coordination between ourselves and them—influence on our part only, not control.

Other than additional resources for them, I don't know of any other particular way to change it.

Mr. MCREYNOLDS. I would concur with what they have said. I've got basically three hospitals that do the majority of the exams, and it ranges from a low of 45 days to one with 130 days. The 130 days has been fairly consistent for the past few months, and you can imagine the effect on timeliness.

Now, that's beyond my control. We try to influence, but sometimes there are other circumstances that make it sort of beyond that guy's control, at the medical center, too. If he loses any specialist and he has no one—especially in the State of Wyoming you would really have a problem finding a psychiatrist for an NP exam. But this is beyond our control. I wish there were some way to make it more consistent across the board.

Mr. SMITH. I think our experience in our portion of Virginia is reasonably good. The three centers that provide most of our examination reports are Hampton, Richmond, and Salem. They do a reasonably good job. It will fluctuate some depending upon staff losses or vacancies, that kind of thing. But I am encouraged that there is a good effort made there to provide us with adequate service.

I'd also, though, echo the statement that I can't wait for AMIE to come along, and I would hope that it is just the first step of many such things to come.

I can see where ADP back and forth between the regional offices and the medical centers in such things as electronic mail, dispatch of medical reports, and things like that could help tremendously. So we all await the future with some promise in that area, I think.

Mr. YODER. Have any of you gentlemen quantified the amount of overpayments that are created if, for instance, a veteran, who, receiving a temporary 100 percent rate because he or she has been hospitalized, is discharged but the regional office is not notified? Or, another hypothetical, a veteran who is getting special monthly compensation for aid and attendance and is admitted to a nursing home at VA expense without notice to the regional office. Have any of you quantified that? Or the other way: veterans who are entitled to the temporary 100 percent pay rate but who don't get it because you haven't been notified?

Mr. GRESHAM. Well, I'm certainly not prepared to give you specific figures now, but I do know the last time the Office of Inspector General did an audit of my field facility they tried to look specifically at that to see if there was any evidence of a lack of control or a serious overpayment problem and they did not find that at my particular facility.

Mr. LEMONS. I don't have specifics, but I can echo Henry's observation. I'm right in a negotiation period now with the IG on a cyclical audit, and that is an area where—one of the things we are trying to negotiate with them is a proper characterization of this problem from how much of it is a hospital problem--failure to notify the regional office—and how much of it is a regional office problem—failing to take action once properly notified.

Mr. MAYE. I don't have any hard data available right now.

Mr. SMITH. I don't have any hard data. We are undergoing an IG review right now. It started Tuesday. I'm sure they are going to look in that area.

Mr. YODER. In your experience in your regional office right now, do you have staff that are not being used at the level for which they are trained and qualified because of other staffing shortages? For example, adjudicators who may have to pull files or do filing because you don't have file clerks; or, as another example—and don't limit yourself to my examples—a chief of veterans' assistance who may have to serve as receptionist because in filling your positions you felt that receptionist was an expendable position?

Mr. GRESHAM. I'm sure my personal experience will be completely out of step with my colleagues because, again, I am at a very small station and the type of thing you described is unavoidable. I typed this myself prior to coming to this hearing.

Mr. YODER. That would be an example.

Mr. GRESHAM. That's not an unusual circumstance for me.

Mr. LEMONS. I would have to say absolutely. There is no doubt that when the resources do not keep a 1 to 1 parallel relationship with the workload demands, you do what needs to be done in whatever activity it is to get the job done. We are hopeful that with the increased budget being directed in our area that we will minimize that situation.

Mr. MAYE. My answer would be yes. There are two areas, in particular. As I stated earlier, ADP—we are doing some of our own ADP development that probably would be better served if it were done on a larger scale by people with more knowledge in ADP than we have. I think some of my staff are well versed with program knowledge, but we are still learning a great deal about ADP.

Second is in training. We use a lot of our resources to train other people. Veterans Benefits Administration developed a training academy, and it is in its initial stages and growing, but it still does not satisfy my need for training. My turnover produces more need for adjudicator trainees than slots that are available to give me, so that means I have to duplicate their effort and local have training in my regional office. So there are two areas that I am directing resources I would prefer not to.

Mr. McREYNOLDS. It does happen. As a matter of fact, it has happened to me recently. We did lose a bunch of file clerks at one time. We had everybody in the division file for one hour in the morning. I don't see any way you could really ever have an optimum staffing level where you could prevent that from occurring. It is lousy labor economics, to be sure, but the fact is: the job needs to be done and it needs to be done then. So I think it will always happen.

Mr. SMITH. We have very little of it. There is some of it Monday mornings. The chief of office services may be opening mail or something like that, but I don't think there is anything wrong with that.

We may have some of that being done in loan guaranty in some of the coding and some of those kinds of clerical things. Every once in a while we will have technicians doing work at a level below their level of expertise.

Those are about the only two areas I can think of recently. We try to control that, and it doesn't happen very often.

Mr. YODER. One final question relating to the consolidated processing of Montgomery GI Bill benefits. Are you able to resolve benefit payment inquiries adequately? Is claims processing at for consolidated stations creating a problem in your resolution of veterans' payment problems?

Mr. GRESHAM. In the Manchester regional office we don't really see that as a problem. I think the program has worked relatively well.

Mr. LEMONS. I see no increased problems as a result of four centers versus one center. The inquiry resolutions I still want to come to my office as these are Texas veterans and I want to serve Texas veterans. The relationship with the Muskogee regional office is excellent, and they give us good service.

Mr. MAYE. Just beyond initial startup problems, nothing significant that we haven't been able to deal with.

Mr. McREYNOLDS. Same here.

Mr. SMITH. I would think we do have a few problems. We have files remote from our own, and we are responsible for inquiries against that file. There is an extra level of difficulty to get responses sometimes. So I'd say yes, it is a little more difficult to get answers for congressional letters or special things of that nature. I think it is a matter of the birthing as much as anything else, and I would hope that these problems will become practically unnoticeable, but I notice a few of them at the current time.

Mr. YODER. I'll yield back to Jon.

Mr. STEINBERG. Thank you, Chris.

I suspect that Senator Murkowski may have written questions for you. As indicated earlier, Senator Mitchell probably will, as well.

This has been the first regional office directors panel that we have had in this committee. I know that Senator Cranston felt it was extremely valuable to have you and appreciated the directness and straightforwardness of your responses and the information that you have shared with us.

I have had the privilege and the pleasure of being with you at some of your regional directors' conferences and in a position where you were propounding the questions to me. I must say I enjoyed it as much on this end, although I also enjoyed that exchange very much on those other occasions.

We are very grateful to you. I want to say briefly in closing that it is a particular pleasure always, of course, to have Jim Maye from our State back here. I have known Jim for many, many years—longer than either of us want to remember, I'm sure—in some of his prior lives. I haven't had too many prior lives, but Jim has had a few. We're delighted to have you back here, Jim. We appreciate all of your help and cooperation and input.

Steve, I remember with great pleasure the very close relationship we had back in the early 1980s in one of your prior existences when we were grappling with reform of the VR program. You were in a position to give us great help informally and great expertise.

It was a pleasure to converse with and meet the other three of you. It is always a great source of pride and joy for us when we see, as you exemplify, the high quality and caliber and great dedication that characterizes VA field officials.

We are greatly in your debt for coming forward. We hope we haven't inconvenienced you. From our end, it was well worth it, and we thank you very much again for being with us. We'll be in touch with you with some written followup questions.

Thank you.

Now we will recall the Independent Budget panel that was with us an hour and a half ago or so: Bob Jones, Jesse Brown, John Bollinger, and Larry Rivers. As they come forward, we will apologize for what was certainly not a brief interruption.

We are depleted by one. Am I correct?

Mr. Brown. That's correct, sir.

Mr. Steinberg. You are no longer here as the Independent Budget panel, but as a panel of representatives of the individual organizations that makeup the core of the Independent Budget Project. So we will proceed with Jesse. If you would, lead off.

Let me again apologize for the timing this morning. As Senator Cranston stressed to you, the very detailed testimony that you have submitted individually, as well as the Independent Budget which we had weeks ago, provided a very strong background for preparing questions for the administration. We hope that you feel as though you were partners and participants in the dialogue that took up the first 2 hours of this hearing, because we feel you were and feel that your work contributed greatly to the ability of the committee to probe as deeply as Senator Cranston was able to. We wish we had had more time this morning, as he indicated. His travel schedule changed, and he has had to leave town.

So you have our apologies. You also have our gratitude for your patience.

With no further ado, Jesse, we would like to have the statement of the Disabled American Veterans.

Mr. Brown. Thank you, Mr. Steinberg.

I think that in order to bring things back in balance I would like to refer this portion of my time to John, who was interrupted in his initial statement to the committee.

Mr. STEINBERG. That's very generous of you. Of course, Jesse, your entire 40-page statement will appear in the record. We are grateful for that contribution.

Mr. BROWN. Thank you.

Mr. STEINBERG. John? I guess you were depleted as well, by the loss of Dr. Custis.

Mr. BOLLINGER. I can't tell you how sorry I am that Dr. Custis had to go to an appointment in Chevy Chase, so I now have a new, very confident backup team that I'm hopeful will be able to answer all of your medical care questions.

Mr. STEINBERG. Fine.

STATEMENT OF JOHN C. BOLLINGER, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BOLLINGER. Thank you very much.

It was my original intent to go into some detail in regards to how we came up with our——

Mr. STEINBERG. May I interrupt you for one moment, John?

Mr. BOLLINGER. Yes, sir.

Mr. STEINBERG. Do you want to use—you now have approximately 4½ minutes of Jesse's time and your own time. Shall we just give you that time now? Your own PVA time, and you can use it any way you wish, as well as Jesse's time.

Mr. BOLLINGER. Thank you.

Let me just briefly summarize how we did come up with that $13.4 billion figure and perhaps talk a little bit about why we think that is so critical after what you know was a number of years of insufficient budgets for health care.

In the case of our fiscal year 1991 proposal for health care, we returned to the fiscal year 1988 appropriation as our baseline. As you know, the fiscal year 1989 figures were such a disaster for the Department and service levels dropped so low in inpatient, outpatient, and nursing home care as a result, no reasonable comparison could be made that could provide any continuity for an ongoing, current services analysis based on what we believe is true veteran demand.

So, just briefly, to sum up our analysis of the administration's proposed fiscal year 1991 funding levels in one sentence, it appears to recognize the dire situation which currently exists in VA health care, but it truly does fall far short of providing the necessary funds to deliver quality health care to eligible veterans. So the VA health care budget still does, in fact, have a long way to go, and we are hopeful that the initial surprise expressed by many of us at the turnaround in the President's budget this year won't lull us into complacency, because that is certainly not where we should be. It is our desire to obtain adequate funding for fiscal year 1991 and, at this point in time, I don't think the President's budget provides adequate funding.

I'd like to discuss several issues regarding health care that we feel very important. First of all, the medical and prosthetics research. As you know, the administration's budget proposes a reduction in funds of $14.1 million from last year's request. This decrease in such an important program is one of the most objectionable aspects of the health care budget. It is unfortunate, because the decrease will not only prevent the start of new research projects. The inconsistent funding and arbitrary OMB cuts over the past 5 years have caused dramatic and disruptive fluctuation in resources and personnel for research.

Research teams need stability. A further reduction of $14 million will severely jeopardize the ability of research staffs to engage in projects with any degree of continuity.

When you look back at what VA research has done since World War II—the cure for TB, the development of the CAT scan, the pacemaker, kidney and home dialysis techniques, the first spinal cord injury treatment centers, the best in wheelchairs and artificial limbs—they all came as the result of VA research.

The Independent Budget strongly urges the committee not to allow these programs to deteriorate. We have recommended a total of $255 million for VA medical and prosthetics research. That's a figure that accounts for years of inflation and budget cuts.

Next, the Independent Budget supports legislation that would provide category A veterans with entitlement to the full array of VA health care services—that's inpatient, outpatient, and nursing home care. Unrestricted outpatient care for all category A veterans would not only make for a better quality of care; it would simplify administrative management, encourage preventive care, and reduce the incident of acute complications. We believe, in the final analysis, it will better serve cost containment.

Not only will reductions in inpatient workload offset some of the costs for the increase of outpatient costs; reductions in inpatient care due to inappropriate hospitalization, better control of diseases such as diabetes through proper and regular outpatient care, and the performance of many minor procedures now done on an outpatient basis that just several years ago required inpatient care. This will all help to offset any increase in treating these additional patients. We therefore urge the Congress to expand outpatient care and nursing care entitlement to all Category A veterans based on the same rules of access to care as applied to inpatient care.

Just wrapping up my statement, I just want to give you a brief comparison of VA health care budgets and other Federal health entities.

As you know, medical inflation rates have been going up at about 8 to 10 percent for the past several years. Since 1985, Medicare has received a 44 percent increase, and Medicaid a 58 percent increase. VA health care, an 18 percent increase. As in the case of research it has been a 7 percent decline. Discounting for inflation, VA funding since 1985 has actually been detrimental.

The President's proposed medical care budget for the VA in 1991 is welcome, but it simply will not solve the problems we face. It does not begin to pay off the debt incurred by the serious underfunding in past years, and we are hopeful that the committee will recommend the funding levels as proposed in the Independent Budget and we certainly look forward to working with you toward that goal.

Thank you.

Mr. **Steinberg.** Thank you, John.

Jesse, I think you have a couple of minutes still remaining, and we'd be glad to yield you one additional if you would like to take a couple of minutes now. You have been extraordinarily patient in bearing with us, and it would be extraordinarily rude of us not to provide you with an opportunity to give the DAV's positions on whatever you would like to give us positions on.

STATEMENT OF JESSE BROWN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. **Brown.** Thank you, Mr. Steinberg.

I would just like to make a couple of points which deviate from my prepared text that will address comments of previous VA witnesses.

I listened to the testimony from the previous VA witnesses here today, and it appears to me that they and we must be evaluating a different accounting system. It is difficult to understand exactly what is happening here, but the fact of the matter is that DAV very carefully and comprehensively analysed the VBA data supplied to us by the Veterans' Administration, and this data represents the official resource from which one can evaluate exactly what is happening within the system.

The fact of the matter is that, as I have already stated, almost 2 million veterans a year are unable to reach the Veterans' Administration by telephone. This is very significant—especially in view of the fact that there are no VSD counselors in 24 of the 75 largest metropolitan areas of our country.

We also know, and VA's official record demonstrates, that staff hours for outreach have been reduced by 40 percent.

Now, if the VA is stating that everything in VBA is absolutely wonderful even though they are cutting back service, we need to say that. But I don't think that we can dispute what official VA statistics show.

For instance we welcome a challenge, with respect to the backlog of pending C&P claims. We stand by our statement that in 1987 there were 167,000 C&P claims pending and now there are almost 700,000. We have prepared a detailed analysis of VA's compensation and pension backlog figures. I'd like to share it with you.

Previous witnesses made reference to how great things are in the adjudication division when we know, again for a fact, that nationwide 20 percent of the adjudication personnel are trainees, and you are not going to convince me—I worked almost 20 years as a DAV national service officer in the regional office—that adjudication trainees can be as efficient as seasoned adjudication personnel.

Another example is vocational rehabilitation. I know that the previous VA witnesses are men of integrity, and I know them personally. But it concerns me that not one of them stated the average time from application for vocational rehabilitation until the initial interview for a service-connected veteran is 100 days. That's the average from official VA Central Office's records. That bothers us because we're talking about the service-connected veteran, for which this entire system was designed to serve.

That's——

Mr. **Steinberg**. You think that perhaps they were not typical regional offices?

Mr. **Brown**. I'd have to conclude that because I do know that they are honorable people. So maybe their statistics do not represent the system. Either that, or the data that is being submitted to VA's Central Office is incorrect. It is one or the other.

We talked about the need for additional vocational rehabilitation specialists. We know that the average workload of the typical VA vocational rehabilitation specialist is 200 cases. In the universe out there, when you examine other State agencies and other Federal programs, there are 60 cases per vocational rehabilitation specialist. You can't convince me that even though we have very dedicated people in the VA that they are capable of producing such glowing statistics given their extremely workload. Something is wrong here. Something is out of context compairing VACO data with data stated by previous witnesses.

I'd like to make another point before I conclude. That has to do with the loan guaranty program. I heard how great things are in the loan guaranty program when, in fact, we know that the cure rate for fiscal year 1989 improved to 74.7 percent. But in 1983 it was 85 percent. So are we setting up a different standard here and saying 75 percent is great?

I just think Congress needs to take a very close look at the aggregate days so that we can make sure that veterans are well served by the VA.

Mr. **Steinberg**. Jesse, thank you very much. You have anticipated one of our questions, which was to ask you to provide for the record the white paper that you are preparing on the C&P processing backlog issue and the differing computations that you and the Veterans Benefits Administration have produced on that.

[The white paper on the C&P processing backlog appears on p. 296.]

Mr. **Steinberg**. We also encourage you—and this goes for each of our witnesses, as well as the other service organizations that are concerned about this—to meet with Mr. Avent and other Department officials to see if there is a way that you can both become satisfied with a single set of data. That may not be possible, but we would urge that that be undertaken, and Senator Cranston certainly did urge that this morning. We hope you will followup.

Mr. **Brown**. Thank you, Mr. Steinberg.

Mr. **Steinberg**. Bob.

STATEMENT OF ROBERT L. JONES, CHAIRMAN, COMMITTEE ON THE INDEPENDENT BUDGET AND NATIONAL EXECUTIVE DIRECTOR, AMVETS

Mr. **Jones**. Mr. Steinberg, thank you.

Of course, AMVETS wholeheartedly has endorsed the Independent Budget and its contents, and I would request that my written statement be entered for the record.

I would like to take just a brief moment in the interest of those panels who have been waiting to follow us to make just two points.

The first point that I would like to make focuses on the other agency that testified here today. Gentlemen, I am most concerned that our national labor exchange is in total disarray and is suffering from a chronic illness that may lead to its eventual destruction. We know that the unemployment insurance has gone through a shortfall of $100 million, which has led to a furlough of staff.

We know that the employment service budget, which the VETS, or Veterans' Employment Training Service, is tied to is facing a $52 million shortfall which will result in the closure of offices within the employment service.

We heard the Department of Labor testify this morning that they are faced with a serious shortage that will impact upon the LVER/DVOP mandated staffing levels. Overall they are coming up approximately $14 million short in their budget. The remainder of that moneys is on the tools that those LVERs and DVOPs must use to do their job, their abilities to travel to perform the outreach they are mandated to do, to go to the military installations to provide assistance to the TAP or the DTAP programs, to attend the National Veterans Training Institute, and so forth.

A serious problem is beginning to develop there, and I am very concerned that that organization may, in fact, be faced with a very serious inability to perform its job.

Mr. STEINBERG. Do you have some specific dollar and resource recommendations you would like to give us in writing?

Mr. JONES. I would like to submit that at a later time, sir.

Mr. STEINBERG. Could we get that next week possibly?

Mr. JONES. Yes, sir.

Mr. STEINBERG. Thank you.

Mr. JONES. I would say that the JTPA 4(C) program needs to be analyzed very closely. It is the last remaining private sector veterans' employment and training program that is mandated by law. It has $8 million budgeted this year, which is approximately $1.5 million short of what it has traditionally been. It is formula driven by the overall JTPA program.

The targeted job tax program, which is another tool, is on again/off again. Traditionally, 5 percent of the annual placements are veterans in that program.

The linkages to the VA vocational rehabilitation program and the veteran center program are very, very critical—especially in view of the projected transitioning of recently separated military personnel back in the civilian labor market.

Our entire VETS structure is based upon the Vietnam era veteran. That sunset clause that is currently contained in chapter 42 of title 38 drives the whole train, and that must be looked at very closely by this body.

Mr. STEINBERG. As you know, legislation has been introduced to deal with the formula issue in that regard.

Mr. JONES. There is, in my opinion, a need for Department of Labor to establish a national veterans employment policy to address this issue and how the veterans' employment training service relates to the overall labor exchange system.

I would also like to talk very briefly about the readjustment counseling service and its role in this. I view readjustment counseling as the total social, psychological, and economic readjustment of that veteran. I suggest very strongly that the readjustment counseling service veteran center program mission needs to be analyzed with an eye toward expanding it to include all combat veterans being defined as those with campaign, expedition, or combat action ribbons, or those who have been involved in terrorist activities.

They need additional resources to adequately staff these veteran centers so that they, in turn, can do the outreach. As we learned in the National Vietnam Veteran Readjustment Study, they are only accessing approximately 10 percent of their clientele. We hear repeatedly from veteran center team leaders that they cannot perform the outreach that is needed.

I would also say that we need to analyze the dual diagnosis issue. We have heard repeatedly about the substance abuse programs, the war on drugs. But in the veterans' community I think we need to start looking very closely at those young veterans who are coming into the VA system who are, in fact, starting to show up that have the dual diagnosis of PTSD and alcoholism—and alcoholism seems to be the No. 1 problem secondary to the PTSD, not substance abuse.

Mr. STEINBERG. There is going to be in fiscal year 1990, Bob, if I may interrupt you for a moment, some quite considerable allocation of moneys from the $60 million add-on to dual diagnosis—substance abuse/PTSD, substance abuse/mental illness types of programs. I have a recollection that it is something like 73 such programs that will be set up. At least that's what we understand from the Department.

Mr. JONES. I would certainly hope some of that money would go into those PTSD treatment teams.

Sir, I will stop right there in the interest of time.

Mr. STEINBERG. Thank you very much, Bob. And thanks to each of you.

Let me also comment, Bob, that we appreciate very much your support for an expansion of the readjustment counseling program, and specifically for legislation to expand eligibility for that program to those who have engaged in combat in various exercises since Vietnam. As you know, the Senate has passed such legislation at least three times. Such legislation is currently pending in the House in S. 13, and we very much hope that you and those others of you that support such legislation would forcefully communicate those views to the other body because you have no problem with this body on that issue.

One issue of concern to us in the Independent Budget is something that we feel is not addressed in the Independent Budget, and that is greater funding for PTSD. So we will ask each of you as independent organizations whether or not you agree with Senator Cranston and the tenor of his questions this morning to the Secretary and other VA witnesses that there is a need for PTSD treatment to be given a greater priority and a greater share of resources by the Department. I'll start with Jesse.

Mr. BROWN. We agree with you 100 percent. In fact, we are going to start to work on that immediately.

Mr. STEINBERG. I believe Dave Gorman has now come to the table. I believe you have been a member for many years of the Readjustment Counseling Advisory Committee.

Mr. **Gorman**. For 3 years, Jonathan.

Mr. **Steinberg**. Three. Well, that's many.

Mr. **Gorman**. That's many.

It is an issue that I think we have to address. The RTI study has obviously pinpointed a crying need—a number of veterans out there who have not come to the system. I think, as Bob mentioned with the vet center program, a lot can be done for outreach.

The waiting periods that the chairman mentioned this morning are horrendous—2 years to get into a program. There are certain programs that may be better than other programs in some veterans' minds.

What we have learned recently is the new PTSD clinical treatment teams—I believe there are 43 of them—aren't really doing what they are supposed to be doing. A lot of them are doing purely clinical work, which is fine, but they are devoting all their time to that as opposed to education within the hospital system—outreach and exporting their knowledge to other clinical teams and other treatment modalities within the system.

There is a dire need to export information and educate other professionals throughtout the system with what is being learned about PTSD in Vietnam veterans.

Mr. **Steinberg**. Their devotion to clinical efforts, however, might be a sign of the fact that there is great demand for their clinical services.

Mr. **Gorman**. Absolutely. What we are learning is any veteran that comes to the hospital with an indication of PTSD or related symptoms is being referred to this PTSD clinical team, which not every facility has, which is an indication of the demand, but it is also taking away from the responsibilities and the functions of what that team was designed to do.

There was a question of expanding the inpatient treatment capabilities within the VA geographically to get veterans in who need it. There is outreach that has to be done. And, I think very importantly to this discussion is the educational component. I don't believe from personal conversations or observations that the PTSD inpatient clinic teams have ever come together in one location for a meeting of the minds as to what has and has not worked in their programs. There is a crying need, for education and the sharing of information and we support that. The DAV supports it wholeheartedly.

Mr. **Steinberg**. Bob? You, of course, mentioned this.

Mr. **Jones**. Yes. We wholeheartedly support expansion of resources to the PTSD treatment effort. I echo the comments made by my colleague, Dave Gorman. We are concerned that the PTSD training teams are evolving into clinical treatment teams which then, of course, as you indicated, substantiate the continuing and growing need for PTSD clinical services.

I think that the VA needs to look at that very closely.

Mr. **Steinberg**. John.

Mr. **Bollinger**. Thank you.

First, as a member of the Independent Budget panel, I'd like to say that our recommendations for funding levels do include expanded programs for PTSD. Paralyzed Veterans of America also has encouraged in the past additional funding for such programs. So we, too, would like to see PTSD addressed more aggressively.

Mr. **STEINBERG**. We appreciate the input from each of you on that very much.

In table 7 of the Independent Budget, an appropriation of $50 million is recommended for physician pay, yet there does not seem to be a mention of an increase for nurse pay. Is there a recommendation some other place in the budget that we have not located of an increase for nurse pay? John, I suppose that would be a question best directed to you.

While you look at that, why don't we move on for a moment and then come back.

I'll ask the other panelists if they have any specific suggestions for how to improve nurse recruitment and retention in VA facilities. Bob, we'll start with you, and when John is ready to respond to that we'll return.

Mr. **JONES**. One of the things that I informally suggested some time ago and I believe is very much appropriate now is we talked increasingly about the DOD cost sharing of resources. We also take a very hard look at the downsizing of the military.

The proposal that I made was that the Department of Veterans Affairs, in coordination with DOD, establish a university to train nursing staff, recruiting those recently separating military personnel who are coming out who have medical specialties. Of course, then, as our recommendations in the Independent Budget, give them equitable pay and equitable training.

Mr. **STEINBERG**. Jesse.

Mr. **BROWN**. As was mentioned by the witnesses, the question of retention of nurses within the VA system is not one that is only unique to the VA; it reflects the problem that we have in society, at large.

Dave Gorman has been working very closely on the medical count, and I think he has some additional comments.

Mr. **STEINBERG**. David.

Mr. **GORMAN**. I would think, Mr. Steinberg, that the provisions introduced last year in S. 13 will go a long way toward addressing the needs of the nursing problem. It is not a new issue. It has been out there for a long time. A lot of minds have come together to try to address the problem. I think, in large part, a lot has been done to address it.

We talked some about nurse scholarships in the Independent Budget, and I think that's still a viable way to go.

There is a lot that has to be done. I understand the administration will be introducing a rather comprehensive bill dealing with it this year. We are open to discussing any provision that will enhance the recruitments and retention capabilities of the VA to get and keep health care professionals.

Mr. **STEINBERG**. Great.

Mr. **BOLLINGER**. I think I got your second question, Mr. Steinberg, and I'd like to respond that we, too, would support that.

We are very much in favor of legislation that would enhance VA education benefits, for example, to attract people into the nursing field or the Montgomery GI Bill. Those types of approaches I think would be very beneficial.

In answer to your previous question regarding the nursing shortage, we did not, in the Independent Budget, recommend a specific figure for nurses. However, we do say that we support S. 13, which emphasizes allowing local hospital directors the flexibility to meet local demand. I think that's where we are coming from on that, and that's what we see as one of the most important——

Mr. **Steinberg**. Within your overall proposal there would be room for the increment that would follow from that?

Mr. **Bollinger**. That's correct.

Mr. **Steinberg**. Thank you. That's very helpful. We appreciate very much your support for those provisions. We believe a fair amount of progress has been made in working out the differences between the House nurse pay bill and the Senate nurse competitive pay legislation. We're hopeful in the not-too-distant future we will have a product of those discussions that will be going forward.

We are going to ask the Independent Budget panel, and we will submit this in writing, to expand on problems that you have with regard to the current RAM, but we'll not go into that this morning in the interest of time and also because it is a very complicated subject.

On page 66 of the Independent Budget, it states, "Lack of management control over program development at the facility level and the inability of Central Office to control medical center missions, programs, and activities results in an unnecessary duplication of services that drain available resources." Similarly, on page 68 you state, "Inefficient or duplicative programs should be disbanded or combined with nearby medical center programs where possible." This sounds very much like the Secretary's justification for his legislation to set up the Mission Commission. Our question to each of you is: do you support that legislation? We'll start with John. Your statement of goals sounds very similar to the goals that the Secretary outlined.

Mr. **Bollinger**. I think the intent here—we don't oppose the concept of consolidation. We don't oppose the concept of a lean, mean Department of Veterans Affairs. I think what we are very cautious about and what we would hope the committee would look very carefully at is consolidating for the purpose of reducing FTEE. The bottom line is front-line service to veterans, whether it be in health care or whether it be in the Veterans Benefits Administration.

It is critical, as far as we are concerned, that veterans and their families and dependents receive first-class service from veterans service personnel, fiduciary staff, those types of people. I think that's the intent here in terms of an overall concept.

Mr. **Steinberg**. Do you have a position on the administration legislation to share with us at this time?

Mr. **Bollinger**. No, sir.

Mr. **Steinberg**. Bob.

Mr. **Jones**. I believe, as John indicated, that first and foremost efficient delivery of services is the bottom line that we are trying to accomplish. I do not believe that it would require legislation for the Secretary of Veterans Affairs to obtain that goal.

Mr. **Steinberg**. Jesse.

Mr. **Brown**. I tend to agree with my colleague, Bob. We were against the Realignment Commission being legislatively developed, primarily because we always felt—and obviously the Secretary has exercised his option to move forward administratively, and we think that's the way it should have been done in the first place.

But, in any event, we are going to reserve our reaction to that commission until we have had an opportunity to take a very close look at its composition, its mission in writing, and so forth, to make sure that it is consistent with what we think the mission of the Veterans' Administration should be.

Mr. STEINBERG. Thank you.

The last question that we have is that we understand that the Independent Budget staff conducted a repeat telephone survey of VA hospitals in November of 1989. We wonder if you could very briefly share with us the purpose and findings of that survey and then supplement that for the record, if you wish.

Mr. BOLLINGER. Certainly. The purpose of it was to provide a current status of VA health care as we expected to receive the President's budget 2 months later.

As you know, our survey was conducted the first week of November. It was a telephone survey of 24 representative VA medical centers.

I don't think that the results we found were too much different from the testimony from your VA medical panel earlier today. Every hospital that we talked to reported that deficits were still being absorbed by workload cutbacks and the use of funds intended for equipment purchase—building maintenance and repair, personnel, salaries, and so on.

In most of the hospitals there was a residual deficit ranging from $1 million to $4 million per hospital after receiving their share of the belated 1989 supplemental. There were multimillion dollar backlogs ranging from $1 million to $17 million in needed but unpurchased equipment. There were between 20 and 50 nurse vacancies per hospital, particularly in intensive care. There were waiting times of between 3 and 6 months for certain specialty clinics.

There were projected funding shortfalls in fiscal year 1990 from $40,000 to $50,000 for prosthetic services and equipment, including wheelchairs and leg braces.

Mr. STEINBERG. We appreciate that response. Please feel free to provide more information for the record.

Vic.

Mr. Reston. I don't have any questions of you gentlemen at this point, but I just want to make sure that you understand it is not because we are not interested; it is just that we know you on a personal level, and should we have any questions or require any amplification we can do it on a personal level. Thanks a lot.

Mr. STEINBERG. Thank you, each of you, for bearing with us.

Mr. BOLLINGER. Mr. Steinberg, could I make one final comment on the Mission Commission——

Mr. STEINBERG. Certainly.

Mr. BOLLINGER [continuing]. That I should have made before. Before the Secretary goes forward with something like this we feel that it is essential that a thorough, unmet-needs study be accomplished in order that we can define the universe of people that will be eligible for health care. I might add that that's the primary reason why we support legislation that would provide outpatient nursing home care to all category A people.

Mr. STEINBERG. Thank you very much.

Mr. BROWN. Mr. Steinberg, before you close it off I have one last statement I'd like to make——

Mr. STEINBERG. We'll have to make sure we give Bob a closing comment, also.

Mr. BROWN. OK. He is the chairman. I guess he can go summarize for the Independent Budget panel.

One of the things that impressed me today in listening to the testimony from the various witnesses is how they were going to spend the money—this $1 billion that we got for fiscal year 1991.

Based upon our analysis of the budget, we don't think that there is going to be any money to improve the quality of health care. That doesn't mean that we do not appreciate the efforts by the Secretary, because we really do. We think that he is an outstanding person and he has done a great job. He has broke a 10-year cycle, and I think it is just the beginning. But we have to view it in the context of how it affects veterans and how we are able to provide for their needs.

The way we look at it, when you back out the $158 million for sequestration, the $94 million for the COLA error, the $65 million for the President's drug war initiative, the $453 million for employee payroll taxes, and another $232 million for inflation, that's over $1 billion right there and we haven't done anything to improve the quality of care for veterans or expand the eligibility requirement for them. I just wanted to make that point for the record.

Mr. STEINBERG. Bob.

Mr. JONES. Very briefly, I would like to thank you for the courtesies of recalling this panel so that we could further discuss the Independent Budget, and I would like to compliment for the record the core staff who worked so hard and so diligently to get this publication out.

With that, sir, thank you very much.

Mr. STEINBERG. We share in your compliment to Frank and Don and all the others who worked so hard on the Independent Budget. They made a great contribution and we appreciate it. Thank you, again, so much for bearing with us through this long morning and early afternoon.

We will now proceed with the next panel. While they come forward—and this is the panel of Dr. Waldman, Dr. Horvath, Dr. Fisher, and Mr. Pannell—we will take a 1-minute break.

[Recess.]

Mr. STEINBERG. We will now reconvene.

The next panel consists of individuals who will address budgetary needs in the areas of VA staffing and research. We welcome Dr. Robert Waldman, Dean of the University of Nebraska School of Medicine testifying on behalf of the American Association of Medical Colleges; Dr. Thomas Horvath, Chief of Staff at the Brooklyn, NY, VAMC, testifying on behalf of the American Psychiatric Association; Dr. Elliott Fisher, Staff Physician at the White River Junction VAMC in Vermont and Assistant Professor of Community and Family Medicine at Dartmouth Medical College, testifying on behalf of the American Federation for Clinical Research; and Roy

Pannell, National Vice President of the American Federation of Government Employees.

Again, our apologies to you for both the late hour and for the scheduling problem which Senator Cranston ran into. I hope he had an opportunity to greet you briefly as he was leaving.

We'll ask Dr. Waldman if you would please begin by summarizing your statement in not more than 5 minutes. We have your prepared testimony. We appreciate each of you getting it into us promptly. It has given us an opportunity to review it.

Doctor, would you please lead off?

STATEMENT OF DR. ROBERT H. WALDMAN, DEAN, UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. **Waldman**. Thank you, Mr. Steinberg.

As you indicated, I am Robert Waldman, Dean of the University of Nebraska College of Medicine.

I wish to thank the committee for the opportunity to testify and share with you my concerns about the funding needs of the Department of Veterans Affairs health care system and the inadequacy of current resources for the Veterans Health Services and Research administration.

Also, as you indicated, I am a member of the Council of Deans of the Association of American Medical Colleges, on whose behalf I appear today.

In view of the fact that my time for oral testimony is limited, I'll not repeat the testimony delivered by witnesses in previous hearings explaining the importance of academic affiliation in terms of quality of care and recruitment and retention. However, I would add that those points can scarcely be overemphasized.

The fact that the University of Nebraska provides approximately $1.5 million a year in support to our VA affiliate demonstrates the close ties and the magnitude of the relationship between the VA and the university.

I'll confine my prepared remarks to the funding needs for fiscal year 1991 and to my experience with the Omaha VA Medical Center both as dean and as chairman of the Dean's Committee, and then expand my statements at your request.

In addition to the University of Nebraska, the Omaha VA Medical Center has affiliations with various other programs in medicine, dentistry, nursing, pharmacy, and the allied health professions.

The Omaha VA is a tertiary care center serving veterans from an area including Nebraska, northwestern Missouri, western Iowa, and northeastern Kansas.

The Omaha VA should provide specialized kinds of care not available in other local VA hospitals. However, presently the Omaha VA is not able to do so because of funding constraints. For example, we have curtailed catheterization procedures and discontinued accepting referrals for such services from other VA facilities because our outmoded and unreliable equipment frequently fails, placing patients in danger.

Staff shortages compromise our ability to serve best the needs of veterans in some of the most basic ways, including blood drawing, performing electrocardiograms, and transporting patients.

Limitations on the number of nursing home beds prolongs the hospital stay of some veterans, and in doing so exposes them to additional risks of infection while awaiting available space in an appropriate long-term care setting.

These are only a few of many possible anecdotes which illustrate the stress under which the VA is functioning.

I am concerned about the impact continued budget shortfalls will have on the VA health care system. The $12.3 billion medical care appropriation contained in President Bush's fiscal year 1991 proposed budget is encouraging; however, even $12.3 billion will not allow VSRA to overcome its current shortfall and sustain a well-balanced program.

I commend Senator Cranston for requesting supplemental appropriations to see the VA through fiscal year 1990.

For fiscal year 1991 we should reverse the trend that has necessitated supplementals in the past. I cannot emphasize strongly enough the need to authorize a level of appropriations for VA medical care that precludes the need for midyear supplemental appropriations.

Funding that arrives late in the year does little to improve our ability to replace staff. Administrators can plan more effectively and patients are served best by a reasonable, year-long spending plan.

In the area of research, the proposed fiscal year 1991 appropriation of $198 million represents a real cut of $14 million from fiscal year 1990.

Funding for the health professional scholarship program was also denied an increase.

I respectfully urge Congress to rectify the shortcomings in these areas.

The cuts proposed in the President's budget fail to recognize the benefits of research and the role research plays in the VA's mission. In past years the VA has been fortunate to receive a generous transfer of funds to the research account from the Department of Defense.

I certainly support this and don't want to imply that this shouldn't happen; however, I believe it would behoove the future stability and security of the system to receive appropriate funding through its own budget line item rather than be forced to continue to rely on the Department of Defense.

In the interest of publicizing the needs of the VA, the AAMC joins the Friends of the VA Medical Care and Health Research, a coalition of organizations, in supporting fiscal year 1991 recommendations of $13.4 billion for medical care and $268 million for research.

I request that the full text of the Friends of the VA proposal be included in the official hearing record.

The situation in Omaha is representative of the situation nationwide. More than Band-Aid measures are needed—specifically, a fiscal year 1991 appropriation above the President's budget proposal.

Thank you for the opportunity. Of course, I'll be happy to answer any questions.

[The prepared statement of the Association of American Medical Colleges appears on p. 206.]

[The Friends of the VA proposal appears on p. 255.]

Mr. STEINBERG. Thank you very much, Dr. Waldman. I might just interject for a moment that on the question of supplemental funding that Congress certainly wanted to agree with you that it is not the way to go about doing things, and, as a result of some unanticipated factors, the fiscal year 1990 appropriation did not turn out to be sufficient to carry out the purposes that Congress intended when it developed that appropriations bill in the months of October and November. But there is no doubt that Congress is sensitive to the problem that you suggest, and I believe that both Houses have that view.

We will next hear from Dr. Thomas Horvath, Chief of Staff of the Brooklyn, NY, VA Medical Center, representing the American Psychiatric Association.

Dr. Horvath.

STATEMENT OF DR. THOMAS B. HORVATH, CHIEF OF STAFF, VA MEDICAL CENTER, BROOKLYN, NY, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. HORVATH. Thank you, Mr. Steinberg.

While the organizations I represent, the American Psychiatric Association and the Association of VA Chiefs of Psychiatry are delighted with the improvements in the funding represented in the President's budget, we nevertheless support the alternative Independent Budget which is also supported by the Friends of VA Medical Care Coalition, recommending $13.4 billion for health care and, most importantly, $268 million for health research. My remarks will focus on research, not implying that the other issues are not important, but I just want to emphasize that critical need.

We are concerned that the President's budget actually proposes a cut of $14 million, which, with the high cost of biomedical inflation, will translate to more like $20 million. And if we don't get the usual DOD research transfer dollars, the cut would amount to about $30 million below last year.

In the early 1980s, all approved grants were funded. Last year only 50 percent of meritorious grants were. In 1991, perhaps only 10 percent of new, approved, and meritorious grants may be funded, and existing grants may be reduced. This will have serious consequences, not only for VA research, but for health care, as well.

Research in the VA has two functions: first, to find scientific solutions to the health problems of veterans, and VA psychiatry has a proud record of achievement in areas in PTSD research, psychogeriatrics, Alzheimer's disease, and schizophrenia.

Equally important, however, is the recruitment and retention of highly-qualified individuals. The poor salary structure and diminishing research opportunities had a significant impact on this so that currently nationwide there is, indeed, a 19 percent vacancy rate for psychiatrists. As Dr. Gronvall was not aware of those figures I would very much like to introduce them through my testimony.

The 1990 retirement provisions will make this much worse later this year.

I'd like to deviate from my written testimony and give you a personal example of the interaction between research and medical care.

In 1979 the Bronx VA situated in a deteriorated neighborhood was unable to properly staff its unaffiliated psychiatry program. The clinical service received violation notices from the Joint Commission and the FDA. Conditions were almost as bad as those portrayed in the movie Born on the Fourth of July.

Fortunately, the VA Central Office had the good judgment to build not only a replacement hospital, but an excellent research building, as well.

The VA medical center, and the Mount Sinai School of Medicine had the vision of attracting a group of young clinician scientists from Palo Alto VA and Stanford. They did that by using medical school seed money and access to the competitive funding of VA medical research.

By 1980 a research unit was established. By 1981 we had a full complement of qualified staff and residents equal in quality to other training programs in New York City.

By 1982 we had a spotless Joint Commission and FDA record. We had excellent occupancy, utilization, and quality assurance. And we were funded as the VA's first Schizophrenia Biological Research Center.

By 1984 the National Institute of Aging funding followed for the first Alzheimer's center to be established at a VA hospital. But this proud achievement is threatened now.

Last year the Bronx VA began to experience difficulty in attracting young clinicians and scientists. Our salary rates are completely uncompetitive. We lost clinical support staff due to financial problems with the hospital. And only 50 percent of approved meritorious grants were funded. This will get worse in 1991.

The university supports the staff at the VA generously with salary supplements, travel support, secretaries, technicians, and items that the VA simply cannot supply. But if the scientific group fails to obtain continued research funding and if their ability to conduct quality research is compromised, the university may well transfer its research focus and investigators to other affiliates that are eager to support by now this nationally-known research group.

Strong solicitations have been received from the city and the State. The Bronx VA will once again be unable to recruit quality psychiatric staff, the residency training program will collapse, and medical care in psychiatry will suffer.

Adequate research support is a vital component of the VA health care mission. Please don't cut it. Please increase the support in 1991 to $168 million. I think it is one of the best investments Congress can make.

[The prepared statement of the American Psychiatric Association appears on p. 210.]

Mr. STEINBERG. Thank you very much. And thank you for summarizing in less than 5 minutes.

Dr. Elliott Fisher is our next witness. He is an Assistant Professor at the Department of Community and Family Medicine, Dartmouth Medical School, and also a staff physician at the White River Junction VAMC. He is representing the American Federation for Clinical Research.

Dr. Fisher.

STATEMENT OF DR. ELLIOTT FISHER, ASSISTANT PROFESSOR, DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE, DARTMOUTH MEDICAL SCHOOL, ON BEHALF OF THE AMERICAN FEDERATION FOR CLINICAL RESEARCH

Dr. Fisher. Thank you very much.

My name is Elliott Fisher, as you mentioned, and I am a staff physician at the White River Junction VA in Vermont.

I am actively engaged in patient care, teaching, and health services research at the VA, and I am here representing the American Federation for Clinical Research regarding fiscal year 1991 research funding within the VA.

I wouldn't be practicing in the VA were it not for the VA research program. In 1985 when I was looking for my first faculty appointment I chose the VA over other excellent opportunities. Why was that.

First, my major research interest is in the problem of assuring access to high-quality care for disadvantaged populations. The VA gave me the opportunity to pursue that research interest directly.

Second, in 1985 the White River Junction VA had an active health services research program, and a senior investigator who could serve as my mentor as I began my career. But now that research program is seriously threatened.

In 1985, as has already been mentioned, the VA funded 722 merit review awards, but it is expected to fund only 539 in 1990. And the percentage of approved awards that are actually funded has dropped substantially from 80 percent in 1985 when I was hired to 45 percent in the current fiscal year.

Five years ago we had pretty good odds of getting research proposals funded. Currently we have less than a 50 percent chance of getting meritorious proposals funded within the VA.

This situation is particularly unfortunate because an adequately funded research program is essential to both veterans and the VA hospitals. The research program and academic affiliations create an intellectually stimulating environment that fosters good medical care.

The research program provides the opportunities for veterans to participate in trials of promising new treatments.

Investing in health policy and health services research will improve our understanding of the current role of the VA in the health care system.

How can we possibly plan for the future of the VA without knowledge of how that system interacts and integrates with the rest of our health care system.

Frankly, what made the VA an appealing career option for me and many of my colleagues was the opportunity to conduct research. A recent study by Klemm Analysis Group confirms this impression. Rebecca Klemm, who was responsible for the study, has reported that VA physicians believed that research opportunities were the most important factor in adequate recruitment and retention. Consequently, it comes as no surprise that as opportunities for research support have fallen, many VA physicians have begun to pursue careers outside the VA.

I have seen the impact of these changes at the White River Junction VA. The senior colleague who recruited me, who has been my strongest supporter and strongest advocate within our hospital, is now discouraged about future funding opportunities within the VA and has shifted his research focus away from VA-based research. If, as I expect, he withdraws completely from the VA, it will be a major loss to our hospital and to research in veterans' affairs.

For fiscal year 1991 President Bush has recommended a VA research budget of $198 million, as we have already heard. This is a 7 percent decrease below the budget for the current year. The Bush proposal sends a disheartening message to VA physicians such as myself about the Government's commitment to our research program and its importance to the medical care program.

While the need to reduce the deficit may have been a limiting factor, it did not stop the President from requesting a 36 percent increase for funding for the space station, a 50 percent increase for the superconducting super collider, or a 100 percent increase for the Department of Energy R&D.

We don't intend to question the merits of these programs, but we do question the astonishingly low priority the President has placed on our extremely productive VA research program.

This is particularly disconcerting given public support for health research efforts. A national survey conducted at AFCR's request last year by Opinion Research Corp. found that when asked to State their No. 1 research objective among five specified goals for science, the greatest proportion—53 percent—said improving health care; while only 4 percent viewed space exploration as their number one priority and only 7 percent cited energy R&D as their top priority.

The AFCR supports the Friends of VA Medical Care and Health Research Coalition in recommending a fiscal year 1991 VA research budget of $268 million. This recommended budget will restore the program to its 1985 level of effort and allow for a limited number of special initiatives to address the health problems of veterans.

The AFCR believes that a budget of $268 million is essential if the VA research program is to be restored and stabilized and if the current problems of recruitment and retention that we face are to be overcome.

I'd be happy to answer any questions. Thank you very much.

[The prepared statement of the American Federation for Clinical Research appears on p. 214.]

Mr. STEINBERG. Thank you very much, Dr. Fisher.

Our final witness on this panel is Mr. Roy Pannell, National Vice President, American Federation of Government Employees. We welcome you to our hearing and will be delighted to hear from you.

STATEMENT OF ROY E. PANNELL, NATIONAL VICE PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Mr. **Pannell.** On behalf of our national President Sturdivant, he wishes to give his concern. He was not able to be here, but he picked the best possible person to replace him. I guarantee you that. [Laughter.]

Mr. **Steinberg.** We're sure of that.

Mr. **Pannell.** As you stated, I'm Roy Pannell. I'm National Vice President, American Federation of Government Employees, AFL-CIO. On behalf of the over 700,000 Federal employees represented, I thank you for this opportunity to testify on President Bush's 1991 budget proposal for the Department of Veterans Affairs and for the recommendation contained in the Independent Budget.

Our union represents over 125,000 employees in the Department of Veterans Affairs. Our members are the ones who, on an everyday basis, do the work to provide the services promised to the various veterans benefits programs.

Most of those who have testified here today are on the receiving end of these services and have felt the pain of inadequate funding of veterans' programs. Our members feel this pain every day, albeit from the perspective of trying to do the huge and enormously important job without the resources for that job as well as they would like.

The administration's 1991 budget proposes an increase of $961 million over the current fiscal year 1990 spending, but this is really a cut worth over $700 million below the true current service levels. Although the concept of current services has lost its meaning over the last two administration budgets, it is still a useful measure, and we are indebted to the Independent Budget for providing an honest and realistic picture of the minimal funding needs of the Department of Veterans Affairs based on last year and the full current service funding.

AFGE members are concerned that the American veteran receives a full range of benefits and services to which they are entitled. As mentioned, our members are the direct providers for many of those services. Dramatic changes are needed in the Department of Veterans Affairs in order to allow these services to be provided in sufficient quantity and quality to demonstrate our Nation's gratitude to the veterans and the respect due to the employees of our Government.

The crux of the problem of the VA medical care program's underfunding and understaffing is addressed throughout the budget. In short, the system has been asked to do more with less for so long it is now in a virtual State of crisis.

At the same time the resources have been reduced, Congress has added benefits to the existing veteran care entitlements and has expanded the health care system. Make no mistake: our union applauds Congress' efforts in these areas to improve the veterans' benefits. It constitutes sound public health policy.

The problem for both veterans and employees of the DVA is that these expansions and benefits have been implemented within existing appropriations.

In the provision of health care, it is impossible to choose which is more important: equipment or personnel. A patient needing a respirator needs a qualified medical professional there to operate the respirator. If you have a qualified medical person there without the respirator the patient needs, then that medical person cannot do their job.

These are the tough decisions inadequate funding has placed upon the VA administration. There is a serious equipment purchase backlog in the VA. There is also obviously a serious shortage of personnel in some VA hospitals.

A major reason why the shortage exists forms a vicious circle. First, the VA is underfunded and cannot afford to hire the many health care providers that are needed. Second, the VA cannot afford to offer pay and benefits comparable to what is offered in the private sector, and therefore cannot attract the personnel it is authorized to hire. These two problems entail a third problem for VA personnel, which is that they are expected to carry out an ever-heavier workload despite inadequate resources to work with and inferior pay and benefit packages. Thus, recruitment and retention problems, added to what might be called planned or avoidable understaffing, has created a virtual staffing crisis.

VA hospitals suffer continual problems in retention, recruitment, and overwork of existing staff. In the VBA the situation is the same. The consequences of underfunding have been staggering in the backlog in areas of veterans' claim processing. The understaffing causes undeserved frustration for veterans and serves as stress for veterans in the DVA.

Let me get away from my printed text and tell you from the heart: I represent Indiana, Kentucky, and Ohio. I have been in every VA facility in the three-State area. I have toured all the facilities, and the big question that has been brought up to here today from the medical professions is: we make these budget cuts, but we don't look at how we are going to get the job done. It has been addressed very well throughout the day. The nurses are working 12-, 16-, and 18-hour shifts. They need rest.

We are understaffed. We are not serving the veterans as we should.

I have talked to them. It is a very big, critical problem. They need assistance. They need help. This plan will allow us to hire more people. We wholeheartedly endorse it.

I heard mentioned earlier today of how they are getting the job done. They are making people or asking people to do things they are not normally qualified to do. They are misassigning people to get the services to the veterans. Our veterans deserve more.

As I entered several facilities there was a sign outside that I think means a whole lot to this country. It says "The price of freedom is visible here." We owe them more.

I thank you very much.

[The prepared statement of Mr. Pannell appears on p. 216.]

Mr. STEINBERG. Thank you very much for a very eloquent statement. You have anticipated some of our questions, and some of them we will submit to you in writing.

I wonder, Dr. Fisher, if you might want to give us an example of recent VA research activities that have directly helped veterans, and maybe an example of one where the benefits of VA research was experienced far beyond VA and veterans.

Dr. **Fisher**. There are numerous examples. Let me try to take a couple.

Perphaps the best examples are the initial studies of hypertension treatment and its benefits. Many of the early clinical trials of the benefits of treating hypertension were done within the VA. These studies found that using pharmacologic treatments to treat hypertension prolonged lives and reduced the incidence of stroke.

In the area of alcohol treatment, VA research has demonstrated that outpatient treatment is as effective as inpatient treatment in many cases, with potential savings to the VA that are quite dramatic.

In terms of benefits to the rest of the country, I think the hypertension treatment is quite clear. Early studies in coronary artery bypass surgery were similarly pathbreaking in demonstrating that not only did coronary artery bypass surgery improve symptoms, but it actually prolonged lives. Those studies were carried out within the VA and the findings were widely disseminated throughout the country and throughout the world.

Mr. **Steinberg**. That's very succinct and helpful and we will ask the others to amplify upon that in writing.

Dr. Horvath, would you comment briefly on the adequacy of VA funding for mental health research?

Dr. **Horvath**. Unfortunately, because psychiatry was a later starter in the biomedical research game, its share of research was always less than that of the other specialties.

Forty percent of bed days of care and 25 percent of VA patients are suffering from psychiatric illness; yet, our direct grant support was about 10 percent, and our indirect clinical support for research was only 17 percent. This is much compounded by the fact that we now suffer from a shrinking pie. So we get a small slice of an ever-shrinking pie.

Mr. **Steinberg**. Could you describe the situation at your medical center with regard to the level of staff psychiatrists' satisfaction with VA employment, with regard to staffing shortages in psychiatry, and with regard to the reasons for such shortages?

Dr. **Horvath**. I could speak to two hospitals that I've been in the last year. The Bronx VA that had an extraordinary high morale, our morale was dipping as we were hit by the conflicting demand for increasing caseloads, decreasing funding, the difficulty of attracting new, young staff, and the research cuts.

At the Brooklyn VA where I am now, which does not have an affiliated psychiatry service, we have extreme difficulty. In fact, this VA went through six different chiefs of psychiatry in the last 7 years. It can only employ part-time physicians because the medical school cannot give that support that Mr. Sinai did in the other situation. And as the figures of our survey showed, the national vacancy rates have gone up from 8 percent in 1986, which is the first time we brought it to Central Office attention, to 15 percent in 1988, which is official VA figures. Our own survey done in January was 19 percent.

Knowing the kind of retirement we are expecting with the retirement provisions coming in at the end of this year, we expect that it could be up to 27 percent unless the quadrennial pay legislation comes good.

Mr. **Steinberg**. So your situation is quite severe.

Dr. **Horvath**. The situation is severe in the facilities that I know personally, and our National Chiefs Association keeps a very close contact with each other, and we are extremely concerned there is a meltdown in VA psychiatry unless it is reversed by a couple of ways.

Mr. **Steinberg**. If you would like to supplement your answer in writing with more information from either the APA or your National Association of Chiefs of Psychiatry, we'd welcome that input.

What do you think is the single most-important thing that can be done to enhance the ability of VA to recruit qualified psychiatrists.

Dr. **Horvath**. It is really a two-pronged approach. In the large neuropsychiatric hospitals that are not affiliated, there is no question that the pay is a critical issue. We are completely noncompetitive with State hospitals, and our funding for nurses, for instance, has fallen below the level of the justly maligned State hospital system in the northeast region. So both psychiatrists' pay, but also the adequacy of other health professionals is essential.

The same things are also true with the largely affiliated hospitals, but there the adequacy of research funding is critical. If you have adequate research funding, people will forego the extra salary or the medical school can sometimes come to their aid. Academics do live on shoestrings.

Mr. **Steinberg**. You have anticipated one of our questions with respect to the importance of research.

Dr. Waldman, as noted in your testimony, the University of Nebraska's School of Medicine is affiliated with three VA facilities. Is that correct?

Dr. **Waldman**. Yes.

Mr. **Steinberg**. With different characteristics. Could you please comment specifically on your perceptions of the effects of the VA budget on the functioning of each of those medical centers?

Dr. **Waldman**. Sure. The effect on the Omaha VA is in the purchase and installation of the sophisticated equipment that is needed for a tertiary care hospital and the hiring of non-MD personnel that, as has been indicated, are absolutely essential for the functioning of this sophisticated equipment and sophisticated services.

I think it is less of a problem with respect to the MD faculty mainly because the University of Nebraska essentially underwrites the salary differential that is necessary to recruit these people.

We are willing to do it. I don't say that we are happy to do it. We are willing to do it because, as is frequently mentioned, the VA university affiliation is symbiotic and is mutually beneficial. It is very beneficial to us, particularly with respect to teaching, providing a teaching environment for our medical students and for our residents.

The Lincoln VA is a less tertiary care hospital, and is not—we do not underwrite really the medical staff there because they are not directly affiliated with us; that is, the staff is not on our faculty. I think there the biggest problems are in recruitment of physicians, as well as other health care personnel.

The South Dakota VA that we are affiliated with is, again, a less tertiary care hospital and is also a more rural hospital. It has a tremendous difficulty in recruiting personnel, not only because of the poor salaries, but it is much more difficult to recruit to a very small town in a rural area.

Since you gave us the opportunity to amplify on Dr. Fisher's answer, let me just give you two more examples of VA research, neither of which is with the Omaha VA, but with VAs that I know about for other reasons.

One example is the study of the importance of folic acid and red cell metabolism in the production of red cells. While this was really initially studied because of the folic acid deficiency in alcoholics, the findings have been extended to the general population not only because of that, but also because it was found that folic acid deficiency is common in pregnancy and in women taking oral contraceptive pills, so that, again, the necessity of supplementing diets with folic acid, which was really a study that was done at the VA, are now applicable to the population at large.

The second one I'd like to mention is one which is near and dear to a colleague of the members of this committee and is our junior Senator, and that is the study on prosthetic devices mainly done at the Seattle VA Hospital which have enabled, or course, people who need prosthetic devices to have much greater mobility and to carry out their functions, not only for veterans, but, of course, for the general population who have the need for prosthetic devices.

Mr. **Steinberg**. Thank you for that additional information on the importance of research.

Can you give us, Dr. Waldman, an assessment of how the situation at those three medical centers with which you are familiar compares in terms of the kinds of factors that we discussed with the medical panel and with Dr. Gronvall earlier at the present as contrasted with the way it was a year ago. Are things better, generally, or specifically in certain areas, are they about the same, or are they worse?

Dr. **Waldman**. I think they are getting worse slowly, and the reason they are getting worse is that their equipment is getting older as time goes on; the backlog of replacement of construction that needs to be done to bring things up to par; I think deterioration in morale among all the employees; the fewer number of positions of nurses, physicians, other health care personnel in the VA—all these things are gradually becoming worse. In none of those areas that I can think of are things any better in any of the three VAs or in most of the VAs around the country.

So I think things are gradually becoming worse.

Mr. **Steinberg**. At all three of the facilities?

Dr. **Waldman**. At all three of the facilities. Yes.

Mr. **Steinberg**. I also wanted to note that we share your pride in the Seattle foot and in Dr. Burgess' many innovations and advances.

Mr. Pannell, I'm going to ask you a somewhat different question. I don't know if you are prepared to answer at this point. Your organization has been very helpful in working with this committee in trying to resolve the aftermath of the Colorado nurses case and the attempt to streamline some of the disciplinary procedures that are set forth in title 38 affecting VA health professionals. I believe you have been having some discussions over the last several months with the new VA labor-management team. I'm wondering if you can give us any assessment—perhaps guarded though it may be—as to how those discussions are coming.

Mr. PANNELL. I wouldn't be prepared to address that because I haven't been brought up-to-date on it.

I would like to say along that issue, though, if you could see a nurse who has been through 14 years with the Marion VA in Marion, IN, who is a very active union person, who they had an established contract, cry and give up her vice president's position with the local union because she was committed to go before a review panel on a nurse that was being removed for cause and she knew that she had no protection whatsoever as far as her career and that she was giving up any type of career promotion and she would probably be run out of the VA system. It is very sad that these people cannot have a voice in what is going on in their place of employment.

I appreciate what you people have done in that area, and I wish that you would push forward and talk to the House side and make sure that gets reinstated. We're going to do all we can to help.

Mr. STEINBERG. We wish you would push forward and talk to the——

Mr. PANNELL. But I wouldn't address it because I have not been up to date on it.

Mr. STEINBERG. We have been talking to the House side.

Mr. PANNELL. Yes.

Mr. STEINBERG. We appreciate your cooperation in that, and also the cooperation of your organization in developing the nurse pay legislation which was passed by the Senate this fall in S. 13. Although perhaps you were not in total support of all aspects of that legislation, you were constructive in your criticism and ample in your contributions, and we appreciated that very much.

Mr. PANNELL. The nursing assistants needed help on premium pay on weekends. They don't get any.

Mr. STEINBERG. We are grateful to all of you for joining us today. You have been an extremely enlightening panel. We may submit some additional written questions.

Lisa, I believe you have a question now.

Ms. MOORE. Yes. Thank you, Jon.

My one question is with regard to the VA's research budget and the proposed reduction in that budget. It has been argued by some that because of the proposed increases in NIH funding, which is about 4.7 percent for a total of $7.9 billion, that VA researchers perhaps have ability to try to get some of that research money through NIH or other mechanisms. I'm wondering if any of you could comment on that.

Dr. FISHER. I'd be happy to make a comment about what has happened to the VA research budget over the last 5 years. We have seen a 50 percent drop in the proportion of approved projects that receive funding. That's not going to be made up for by a 4 percent increase in funding in NIH.

We also have serious needs to maintain interested investigators within the VA looking at problems of veterans. The disadvantage of saying, "Let's rely on NIH," is that if you want people to focus on questions unrelated to the needs of veterans in the veterans' health care system, then that might be a reasonable mechanism. However, I think there are pressing problems related to the health care needs of the veterans' population that are best pursued through an active and vibrant VA research program. I'm sure some of the other members of the group may have something else to add.

Dr. **Horvath**. There is also a direct financial disincentive. NIH cannot and will not give indirect research support to the VA hospitals. I'm to lose half of my animal facility because of the drop in merit review funding at Brooklyn and the fact that the medical school has my indirect research support from NIH funds that generate. Because the indirect dollars come to the medical schoo, it really doesn't help me.

Dr. **Waldman**. Just a brief comment. I don't think that one can assume that the minimal rise in proposed NIH budget is going to do anything in terms of having an increased number of grants that are going to be funded.

As you know, the percentage of funded grants by NIH has gone down precipitously in recent years and it is projected it will continue to fall. So VA investigators will essentially not be able to get any relief through the NIH method.

Also, I'd just point out that there also are special research problems that are applicable to VA investigators that it isn't in NIH's general mission to fund. So in those areas the investigators wouldn't get any support, anyway.

I'd just like to end by saying I would hope that—there is a great problem in this country, I think. We have the greatest research group of people, the greatest research initiative that the world has ever seen developed in this country over the last few decades. It is in great danger of falling apart. We are in great danger of losing that. I would hope that the VA would be part of the solution to that problem, not part of the problem.

Mr. **Steinberg**. Thank you. Lisa, I apologize for not introducing Lisa Moore, who is the minority professional staff member who specializes in health matters.

I thank you all and extend Senator Cranston's best wishes and the committee's best wishes to each of your organizations. Our regards to President Sturdivant.

If you will look in Senator Cranston's prepared remarks, which are out on the press table, I think you will see that he is in line with your sentiments in all conceptual respects, and we are very concerned about the research budget request and hope to be influential in trying to improve it somewhat. We thank you all again and will be in touch with you. Thank you for your patience.

Yes, Mr. Pannell.

Mr. **Pannell**. Yes. I'd like to make one other comment. I'd feel remiss if I didn't make it. I felt there was a big gap between what I have heard here in Washington and what I have seen in the field. It has been supported by all of the colleagues that have been here that work out in the field.

Morale out in the field is as low as it has ever been. It is critical. It is at a panic stage. We need some relief. Thank you.

Mr. **Steinberg**. Thank you very much.

Will the next panel please come forward? The panel consists of Samuel Walsh, Deputy Legislative Director of the American Legion; and Thomas Sherwood, Director of Health Policy and Planning for the Vietnam Veterans of America. We welcome each of you and your organizations here this afternoon. We have received each of your excellent and very comprehensive prepared statements and they will, of course, appear in full in the record.

I know that at this point it will be hard to apologize adequately for the late hour, but I will try. We hope that you found the hearing interesting and enlightening. We think that many of the themes that were developed are right in accord with the directions of each of your testimony and, again, we regret the delay. We thank you for your patience. We will begin with Sam if you will please summarize your testimony in 5 minutes. Thank you.

STATEMENT OF SAMUEL J. WALSH, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. **Walsh**. Thank you, Mr. Steinberg.

The American Legion certainly appreciates the opportunity to testify here today. I will limit my remarks to three significant areas of concern in the proposed VA budget for fiscal year 1991, those being the staffing level for the Veterans Benefits Administration, medical care funding, and the needs of the national cemetery system.

The American Legion has expressed continuing concern over the past several years about proposed personnel cuts in VBA and the effects of the continuous loss of FTEE on the quality and timeliness of claims development in the regional offices. The situation continues to deteriorate, as reflected in VA's own figures.

We recommend that a close look be taken at the needs for additional staffing in order to improve the level of service provided.

The increase in medical care funding proposed for next year, while certainly a positive note, will, in effect, only prevent further slippage in the delivery of health care to veterans. As this committee is acutely aware, decremental funding over the past several years has resulted in a deterioration of and cutbacks in the provision of treatment to what are considered by VA to be discretionary veterans—those in categories B and C—and to non-service-connected category A veterans.

Problems exist in the backlog of replacement medical equipment which are not sufficiently addressed in this budget.

We are also concerned about the proposed reduction in research funding.

If VA's medical care is to effectively carry out its mission, it must have adequate and stable levels of funding.

The national cemetery system has suffered from inadequate funding over the past several years to the point that areas such as legislative salary increases and the rising cost of material, utilities, and contracts have received priority funding, which often left insufficient funding for needed maintenance and equipment.

We are pleased that Secretary Derwinski has recently approved the new policy which will permit purchase of land to expand existing national cemeteries when this would be in the best interest of veterans and the VA; however, this will undoubtedly require additional funding. The current resources are extremely constrained, and such additional funding is not certain.

This concludes my statement.

[The prepared statement of Mr. Walsh appears on p. 221.]

Mr. STEINBERG. Thank you very much, Sam. And thank you for being so concise in your summary.

Thomas.

STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. SHERWOOD. The Vietnam Veterans of America appreciates the opportunity to present its views on the budget, the commission, on the future structure of veterans' health care, DVA, VSRA reorganization, and the consolidation of certain loan guaranty operations in New England.

As our written testimony indicates, there is concern that there are no additional dollars requested in the 1991 budget proposals for homeless veterans programs, for inpatient PTSD units, and for the readjustment counseling service. The per diem dollar allocation to medical centers for inpatient PTSD beds based on either RAM model or cost relative to intermediate care programs still do not represent the realities of the true cost of intensive psychiatric care. Yet, indications are that greater resources will be needed in the near future for PTSD and related mental health care for veterans.

There are additional appropriations needed for both PTSD and, as a matter of fact, for Agent Orange compensation relative to pending new legislation. Rather than asking the DVA to absorb those additional costs, they should be appropriated separately.

We are concerned that there appears to be a continuing trend in veterans' affairs which tends to diminish the recognition for service-disabled veterans relative to the allocation of DVA resources. This is ironic in view of the fact that disabled veterans relative to all veterans are, in fact, increasing in numbers.

We are concerned that there is an apparent expanding disassociation between DVA top management at the Central Office level and the field at the veteran service level.

Further, there is a continuing sense of demoralization in DVA staff. The most negative aspect of this concern is that neither the veteran patient nor employees that serve them feel that they have any stake or ownership in the system.

Finally, we strongly support the need for a commission to review the appropriateness of the mission of DVA hospitals for the future. Certainly one of the most important reasons for this support has to do with the need to alert the public and this Congress to the true cost, true commitment, and resources it takes to deliver a quality product called health care to veterans.

The concept of a commission should probably be extended to the benefits side of DVA operations; however, we do not support a commission being created and used inadvertently to assist in balancing the budget or as a means to gain greater control over the DVA system, especially through a process of increased centralization.

Thank you very much.

[The prepared statement of Mr. Sherwood appears on p. 234.]

Mr. **Steinberg**. Thank you, Tom, very much for being brief and succinct and also very informative and direct.

We appreciate the thoroughness and the comprehensiveness of each of your prepared statements. They were very good and very enlightening. And we noted with interest and pleasure the emphasis that each of you placed and the attention that you devoted to the PTSD issue, and we appreciate that very much. You heard our exchange with the prior veterans' service organization panel. We greatly appreciate your calling attention to that and the problems with the readjustment counseling programs' proposed funding and many other issues.

As you know, Senator Cranston is spearheading a major effort currently supported by more than 50 Senators to get the administration to formulate and make a request for supplemental medical care funding for the current fiscal year. Are you in support of that effort? Do you have any figures to enlighten us about what you think would be an adequate supplemental request for fiscal year 1990? We'll start with Sam.

Mr. **Walsh**. I don't have the hard numbers with me right now, Jon. I'd be happy to provide them to you.

[Subsequently, Mr. Walsh furnished the following information:]

Despite a series of last minute efforts during the fall of 1989, the overall budget for fiscal year 1990 failed to meet the Gramm-Rudman deficit target. This prompted an across-the-board cut in dozens of Federal programs, to include a $250 million reduction in VA medical care. The American Legion believes that $11.6 billion is the minimum necessary to meet VA's basic obligations to provide medical treatment. The Congress, therefore, is encouraged to restore this $250 million as soon as possible by approving a supplemental appropriations measure. The impact of this $250 million cut is already being felt in the delivery of VA medicine. Scheduled replacement of essential medical equipment is being reduced by $33 million. Contract nursing home care is being cut by $48 million, and $19 million in medical facility construction projects are being delayed.

Mr. **Walsh**. What we have been doing is looking at the need for a supplemental, and we certainly support and encourage it.

We also have our Washington conference taking place next week, and one of the missions we are turning our people loose on is to encourage the Members on the Hill to proceed with the supplemental request.

Mr. **Steinberg**. Thomas.

Mr. **Sherwood**. Yes. I think that others have to recognize that instead of $1 billion in terms of the request for 1991 that has been requested, some feel it should be as high as $1.6 billion. To be sure, it is recognized—and I thought Jesse put it very well--that the additional $1 billion that might be granted for 1991 will probably all be used to fill in the holes that were created in 1989 and the 1990 current budget. That is to say that in terms of trying to get the system pepped up to be a more functional system, it will probably take a heck of a lot more than the $1 billion that was requested. All of those dollars will be consumed in just trying to get the system restabilized to a previous 2- or 3-year status.

As for the actual additional dollars that will be required or even requested for 1990, there will be additional dollars requested—guaranteed for 1991 and 1992. There is also a matter of the way the VA health care system is designed, its efficiencies and inefficiency, and the need to really redo these systems. I hope the commission will at least make an attempt to do.

Relative to the practices, needs, and products that it takes to deliver health care, I think the VA costs are, in terms of the dollars that are needed to support a modern health care system, considerably high. I think the commission will prove that, in fact, the public may have to make a decision not about $12.2 billion but much more. If we really cost out the system in terms of what VA health care is really doing and what we really want to do for veterans, it may be a $15 billion system, and that's a reality that at some point if we are going to continue to do what we want to do for veterans we may have to face.

Mr. STEINBERG. Thank you.

On page 17 of The American Legion's written testimony, it states that VA's medical research budget for 1991 is really about $35 million less than for fiscal year 1990, taking into account all factors. VA has testified that expected reimbursements from DOD and other Government agencies would more than offset this difference, resulting in a net increase over fiscal year 1990. Would you each please comment on that situation and that VA assertion?

We'll start with Sam.

Mr. WALSH. I'd like to refer to my comments to the last panel. As I recall, the last panel indicated we need dedicated research funding for VA. It is very difficult to base your spending on what you think DOD is going to do. We believe that the funding for VA research ought to be a stand-alone line item and dependable and reliable from year to year. We stand on that.

Mr. STEINBERG. Thomas.

Mr. SHERWOOD. To be very honest, I think that the hopeful turnout that we will realize additional dollars from the "peace dividend" is, indeed, exactly that—hopeful. I don't think that if there is going to be a peace dividend, in spite of all the changes that are occurring in the world. We probably will not be able to realize that for at least 2 or 3 or 4 years down the road. I guess I can say in terms of some information that Colin Powell shared with us at the White House, there will not be many dollars available in terms of a peace dividend as it appears he feels that, of course, the Defense budget has to be online and we must be in a state of preparedness.

To be sure, in terms of any peace dividends that come, I am not clear that those folks that make the decisions other than the Secretary will think of veterans first, so my advice is we shouldn't depend on this peace dividend. We need to really look at a strategy in terms of the overall budgetary system that gives the priority and the recognition to the veterans that they deserve.

Mr. STEINBERG. Thank you.

Lisa

Ms. MOORE. No questions.

Mr. STEINBERG. We have come to the end of a very long day. We thank you very much for your patience and for your contributions and your oral testimony and your prepared statements.

I want to note that we have written testimony submitted for the record from the Association of Professors of Medicine, from the Manufactured Housing Institute, from the California Association of Realtors and the Mortgage Bankers Association, the National Association of Realtors, the National Association of Home Builders, and the Non Commissioned Officers Association. Those statements will appear in the record at the appropriate point.

We thank those last few who remained with us and our reporter for extraordinary perseverance and fortitude.

This hearing now stands adjourned.

[Whereupon, at 2:36 p.m., the committee was adjourned, to reconvene on Tuesday, February 27, 1990.]

APPENDIX

II

101st CONGRESS
2d Session

S. 2101

To waive the waiting period requirement of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization involving the Loan Guaranty Division at the Togus Veterans' Affairs Medical and Regional Office Center.

IN THE SENATE OF THE UNITED STATES

February 7 (legislative day, January 23), 1990

Mr. Cranston (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To waive the waiting period requirement of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization involving the Loan Guaranty Division at the Togus Veterans' Affairs Medical and Regional Office Center.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the waiting period requirement of section 210(b)(2) of title 38, United States Code, shall not apply to a Department of Veterans' Affairs planned administrative reorganization that involves the closing of the Loan Guaranty Division at the Togus Veterans' Affairs Medical and Regional Office Center, and the transfer of the functions of that Loan Guaranty Division to the Manchester Veterans' Affairs Regional Office.

○

II

101st CONGRESS
2d Session

S. 2103

To waive the reporting and waiting period requirements of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration.

IN THE SENATE OF THE UNITED STATES

February 7 (legislative day, January 23), 1990

Mr. Cranston (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To waive the reporting and waiting period requirements of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary may implement an administrative reorganization within the Department of Veterans' Affairs to reduce from seven to four the number of regional field offices of the Veterans Health Services and Research Administration without regard to the reporting requirement and waiting period provided for by section 210(b)(2) of title 38, United States Code.

○

PREPARED STATEMENT OF CHAIRMAN ALAN CRANSTON

Good morning. Welcome to today's hearing on the fiscal year 1991 budget for veterans' programs and on legislation (S. 2101 and S. 2103) to waive the statutory notice-and-wait requirement with respect to two proposed administrative reorganizations.

Our agenda is very full this morning. Today's witnesses include panels from the Department of Veterans Affairs, the Department of Labor, the U.S. Court of Veterans Appeals, veterans' service organizations, VA field officials from several VA medical centers and regional offices, and organizations involved with VA health care and research.

Before getting to the issues involved in today's hearing, I would like to thank the Secretary and the many other VA officials who worked so hard in preparing the agency's testimony and answers to my many prehearing questions and the informal inquiries made by committee staff members on behalf of the committee. A special note of thanks to Marie Pringle in VA's Budget Office for coordinating those answers.

Unfortunately, I also must note my disappointment with the delays caused by the Office of Management and Budget in their review of these answers. Almost all of the questions concerned factual information and I do not believe OMB was justified in holding up VA's responses. Although we received some answers yesterday evening, most of the formal questions are still unanswered.

I want to thank the many other witnesses who cooperated with us in providing their testimony in a timely fashion as requested. Your efforts are very much appreciated.

BACKGROUND

Last year, our committee reported its views and estimates to the Budget Bommittee on a bipartisan vote of 8-3 and I will do all I can to reach a bipartisan accord again this year. Our budget blueprint last year also was right in line with that approved by our counterpart committee in the House, and I also am doing my best, with the cooperation of Sonny Montgomery and Bob Stump, to move ahead on a consistent path this session as well.

MEDICAL CARE

GENERAL HEALTH ISSUES

The $12.28-billion request for the Medical Care account for the coming fiscal year is an 8.4-percent increase of nearly $956 million over the funding level available for the current fiscal year. It is the best VA Medical Care request submitted by a President in over a decade.

This good news for America's 27 million veterans is the result of the very effective advocacy of the first Secretary of Veterans Affairs, Ed Derwinski, who took his case directly to President Bush and did a tremendous job in convincing him that the downward spiral in VA health care must be halted. My hat is off to the Secretary for bringing about this major breakthrough in the battle to overcome the large budget shortfall VA has been saddled with since the summer of 1988.

In addition, many of my colleagues in the Senate themselves made effective efforts in support of increased funding for VA health care. Twenty Senators joined me in an October 1988 letter to President Reagan, 40 Senators joined me in a January 1989 letter to President Bush, and 40 Senators joined me in a December 1989 letter to President Bush. At the moment, 50 Senators have joined me in a pending letter to the President, urging again that he submit a supplemental funding request for VA medical care in the current fiscal year. Each of these letters represents a strong statement of congressional support for the VA health-care system.

Veterans' service organizations also have been pressing hard for an improved VA health-care system, through contacts with Secretary Derwinski, the President, and the White House Chief of Staff.

Before noting some positive matters included in this request, I want to join with the Paralyzed Veterans of America in recognizing two negative elements of recent administration budgets that are not in this budget. First, there is no arbitrary 1-percent reduction for phony "productivity improvements"—though I would note that there is a smaller, nonspecific $28.1 million, 531 FTE reduction entitled "resource redirection" of which amount to a cut of two-tenths of a percent.

Second, the budget does not require any absorption of the Medical Care account costs of the January 1991 pay raise. That is indeed a major improvement. Unfortunately, that approach was not extended to the other affected accounts—the research MAMOE, GOE, and Minor Construction accounts—which are forced to absorb half of the costs of that pay raise.

As I indicated, the FY 1991 VA medical care request contains a number of very positive features. The $12.28 billion, while not including everything that is needed, would allow for the restoration of at least 2,337 full-time employee positions, including nearly 800 more nursing positions. This request also includes very welcome proposals for funding of an anticipated 3.5 percent January 1991 pay raise; for $70 million more for pay boosts for VA doctors and nurses; and for $8.3 million for improved health-care quality assurance programs. I an encouraged by the proposal for $4.3 million to resume a process I have advocated for over 10 years to control ward drug stocks and by the President's goal of completing conversion to this unit-dose system by 1995.

The VA proposal also includes an increase of $31.4 million to fund VA nurse pay reform legislation. Last May, I introduced legislation to require each local VA hospital director to establish and maintain a VA nurse pay scale that is competitive with nurses' wages elsewhere in the community. Provisions of that measure were then incorporated into an omnibus veterans bill and passed by the Senate last October. Although these provisions have not yet been enacted, we have been working with the House Veterans' Affairs committee over the last few months to reconcile the different Senate- and House-passed nurse pay provisions. I feel we are making progress.

The President's budget also includes an increase of $38.6 million to fund increases in special pay for physicians and dentists. I will shortly be introducing legislation to increase pay for VA doctors. The administration's request for funding is a recognition of the urgency of the problems VA faces in recruiting and retaining high-quality doctors and nurses and will definitely facilitate the enactment of legislation to enable VA to be more competitive in the health-care personnel marketplace.

However, even with the significant infusion in funding proposed by the President in the Medical Care account, some important needs are not dealt with adequately. I would like to see more emphasis on the needs of veterans for extended care and geriatric programs, and for innovative ambulatory care approaches to avoid institutionalization. I anticipate urging that increased funding for these purposes be included in our committee's recommendations to the Budget Committee.

MEDICAL AND PROSTHETIC RESEARCH FUNDING

In contrast to the generally positive Medical Care budget, the proposed 7 percent, $14.1 million cut in medical and prosthetic research is shortsighted and a big disappointment. Not only does VA research make a major contribution to our national effort to combat disease and disability, but it is vital to maintaining a high quality of health care for the individual veteran patient and attracting highly-qualified health and mental health professionals to VA by improving the professional milieu in which they work.

THIRD-PARTY REIMBURSEMENT

I also have reservations about the proposal in the budget for a large-scale effort to beef up collections from health insurers by assigning 800 employees—including apparently 300 new ones—to these duties and by charging insurers for the non-service-connected care of seriously disabled service-connected veterans.

I am not convinced we need a new corps of Federal bill collectors. I would prefer that VA contract out as much of the collection activity as possible and keep its own work force focused on patient care.

Moreover, the VA proposal to require health insurers to pay for part of the care furnished certain veterans with serious service-connected disabilities could raise innumerable disputes as to whether the care involved is in any way related to a service-connected condition. Such a requirement would also involve sloughing off onto the private sector substantial costs for the care of severely disabled service-connected veterans—specifically those with disabilities rated at 50 percent or more—for whom the Federal Government has a statutory obligation to provide comprehensive care.

NEED FOR FY 1990 SUPPLEMENTAL APPROPRIATION

The generally positive funding levels in the budget for FY 1991 stand in stark contrast to the funding situation confronting VA health-care facilities this fiscal year. I feel strongly that the beneficial request for fiscal 1991 makes it very obvious that there is a critical need right now—not 7 months down the road—for supplemental funding for the current fiscal year. In this regard, as I noted earlier, I have been joined by at least 50 other Senators in a pending letter to President Bush urging that he extend his commitment to VA health care by submitting a FY 1990 $252.4 million supplemental request to restore the shortfall—resulting from sequestration and a VA miscalculation in personnel costs—that was not anticipated when he signed the FY 1990 VA, HUD, and Independent Agencies Appropriations Act into law on November 9, 1989.

Over the last few years the VA health-care system has been experiencing serious instability, lapses in quality, and significant cutbacks as a result of the start-and-stop funding it has been receiving. Many VA medical centers have been forced to cut back on staff, close beds or even entire wards, shut down innovative and effective programs—like those for drug and alcohol treatment and hospital-based home care—curtail community nursing home placements, postpone activations of completed facilities, and delay, often for dangerously long time periods, vital equipment repairs and purchases. Not all hospitals have been affected in the same way; some were in a crisis situation in fiscal 1989 while others began being seriously stretched this past fall. But all facilities are experiencing major backlogs in replacement and repair of critical lifesaving or life-extending equipment.

There is no question that the current FY 1990 funding level will mean that tens of thousands of veterans will this year be denied the quality of care—or denied the care entirely—that we owe them. Without additional fiscal 1990 funding, the VA health-care system will have to reduce staffing and service levels throughout the year, only then to begin to restore many of those cuts beginning on October 1 with approval of the FY 1991 appropriation. Such wide swings in resources run directly counter to the goal of building a high-quality, stable staff of health professionals who can work together smoothly.

It would be a cruel hoax on our sick and disabled veterans to dangle an improved health-care system before them if they can only hold on for another 8 months. Many will not survive to gain the benefit of the President's fiscal 1991 request and others will grow sicker while effective and timely treatment is postponed.

That is bad medical care and bad public policy. I am convinced that the VA health-care system cannot furnish a high quality of care unless it is provided consistent as well as adequate funding levels.

I am encouraged by the commitment to the VA health-care system manifested in the President's FY 1991 Medical Care budget request, and therefore will continue to urge him as earnestly as I possibly can to fulfill that commitment now by submitting an FY 1990 supplemental request of $252.4 million to provide funding this fiscal year for the level of services that the budget request contemplates for FY 1991.

MENTAL HEALTH ISSUES

PTSD Care: At last year's budget hearing, I discussed the alarming findings in the Research Triangle Institute's 4-year study of the readjustment problems faced by Vietnam veterans. RTI found that 479,000 male Vietnam veterans currently have full-blown cases of post-traumatic stress disorder, while another 350,000 Vietnam veterans have PTSD symptoms that warrant care. The study also found that in the 12 months prior to the study, only 22.3 percent of those with PTSD had used some mental-health service and only 10.3 percent of those with PTSD had used VA mental-health services. I am extremely disappointed that, despite the clearly demonstrated need established by the RTI study, which the agency has never challenged, VA proposes no increased funding for PTSD care above the FY 1990 dollar level.

In fact, there is nothing more incomprehensible to me in this budget than the lack of a demonstrated commitment on the part of the Department to begin to tackle its responsibilities to the hundreds of thousands of Vietnam veterans—and other war veterans—who are suffering from this serious psychological disorder which they incurred as a result of their combat experiences.

What is the purpose of a Department of Veterans Affairs if not to respond all-out to such a clearly top-priority need? For the third straight fiscal year, the task has fallen to Congress to propose and fight for whatever increases we can eke out for those most deserving veterans in the face of the abdication of leadership by the Department in this area. I will continue to press this cause most vigorously. Over the last 2 years, I have been successful in convincing Congress to add a total of $22 million for PTSD treatment and will be pursuing a comparable increase this year.

Readjustment Counseling: VA's 196 Vietnam-era veterans readjustment counseling centers, known as Vet Centers, help to assist Vietnam-era veterans overcome difficulties they have in readjusting from their wartime experiences. In FY 1989, Vet Centers saw an average of 9,720 veterans each month—an increase of 6 percent over the previous fiscal year. Over the past 10 years more than 600,000 veterans have been seen by Vet Center staff—over 700,000 persons in all, including family members and closely-related individuals, for a total of more than 4 million visits by veterans and others since the program began.

The FY 1991 budget recommendation for the Readjustment Counseling Service (RCS) contains no increase over FY 1990 levels for either funding or FTE, despite the clear success of the program over the last 10 years and the 8.4-percent increase in the medical care request. I believe that what is essentially a service-related program responding to postwar psychological readjustment problems should not be forced to scrape by on such a restrictive budget, especially in light of the enormous need shown by the RTI study in the area of PTSD alone. Without an increase for inflation or normal salary increases, the FY 1991 budget request for Readjustment Counseling amounts to a decrease in program resources.

VA budget documents State the Department's intention to provide Vet Center services according to the levels of need and utilization by the Vietnam veteran population. With VA's own figures indicating that more and more veterans are using the Vet Centers; this and the RTI report should be a sufficient indication of "need" and "utilization" to justify an appropriate Vet Center funding increase. Without an increase, RCS will be forced to meet inflationary costs by using funds allocated for travel and fee care counseling, both of which have undergone cuts in recent years to the detriment of the program's operation and the veterans served by it. I will propose additional Vet Center funding in order to help respond appropriately to the readjustment and mental health needs of the Vietnam-era veteran population.

Care for Homeless Veterans: (1) Domiciliary Care for Homeless Veterans (DCHV) Program—In Public Law 100-71, the FY 1987 Supplemental Appropriation Act, Congress appropriated $15 million for the conversion of underused space to domiciliary beds primarily for the care of homeless veterans. Section 801 of the McKinney Act (P.L. 100-628) authorized the appropriation of an additional $15 million for each of FYs 1989 and 1990. Spending for the DCHV Program totalled $10.36 million in FY 1989, and $15 million has been appropriated for FY 1990. The administration proposes FY 1991 funding at the current dollar level of $15 million.

Many of the short-term needs of our homeless veterans are being successfully met by this program: a place off the street to sleep; the opportunity to receive much needed medical and mental health assessments; and the furnishing of appropriate care and rehabilitative services. None of these services are luxuries—they constitute humane responses to basic human needs. Since the beginning of the program, over 7,600 homeless veterans have been provided care.

According to VA, of the $15 million provided the DCHV program in FY 1990, $10.7 million will be used for support of ongoing program operations. The remaining $4.3 million will be used to expand the program. The number of DCHV programs will be increased from 20 at the end of FY 1989 to 26, adding 205 treatment beds and 72 FTE. The six new programs to be activated are located at VAMCs Bedford, MA; Cincinnati, OH; Dallas, TX; Butler, PA; Martinsburg, WV; and Prescott, AZ. Also, earthquake relief assistance, which I am especially pleased to see, of 10 treatment beds and 9 FTE is being allocated to the Palo Alto DCHV program. VA estimates that the total expansions and enhancements will increase program activities by 215 beds, bringing the total number of DCHV beds to 1,184 this year.

(2) Homeless Chronically Mentally Ill (HCMI) Program—A program of contract residential care for chronically mentally ill veterans was first authorized in 1987 under Public Law 100-6, and in 1988 was mandated as a 2-year—FYs 1988 and 1989—pilot program under Public Law 100-322. Public Law 101-237 extended the pilot program through September 30, 1992. Section 801 of the McKinney Act authorized appropriations of an additional $15 million for each of FYs 1989 and 1990 in order to continue and expand the HCMI program. Spending for FY 1989 totalled $13.25 million, and $15 million has been appropriated for FY 1990. Again, the administration proposes FY 1991 funding at the current dollar level of $15 million.

The HCMI program is a community-based program combining aggressive outreach to veterans with intensive case management and time-limited care in contract residential treatment centers. According to the recently-released third progress report on the HCMI program, between May 1, 1987, and May 31, 1989, a total of 19,697 homeless veterans have been assessed at the program's 43 sites. Previous VA reports have clearly shown that the program is successfully reaching its intended target—the profoundly homeless, extremely poor, and chronically mentally ill. However, the third progress report also estimates that, at any given time, there are between 70,000 and 200,000 homeless veterans on the streets of America—clearly an indication that this program is only scratching the surface of the homeless veteran population.

According to VA figures, of the HCMI program's $15 million appropriation for FY 1990, $13.75 million will be needed for the 43 existing sites to maintain current services. With the remaining money, at least one additional HCMI site is planned to be activated. In view of the severe needs and growing numbers of homeless veterans, I believe strongly that both of the homeless programs require a significant increase in funding for 1991.

Drug and Alcohol Treatment: VA is the single largest direct provider of substance-abuse treatment in the United States, and I believe it to be particularly well-placed to be a leader in treatment efforts. In FY 1989, VA furnished alcoholism treatment to more than 100,000 individual veterans—over 58,000 in 129 specialized alcoholism treatment units on an impatient basis and another 41,500 on other VA impatient units, such as general psychiatry. On an outpatient basis, VA handled almost 450,000 visits during FY 1989 for alcoholism treatment in 139 outpatient alcohol dependence treatment programs.

Also in FY 1989, VA's 53 drug dependence treatment programs provided treatment on an inpatient basis to 29,500 individual veterans with a wide variety of drug abuse and dependence problems, including heroine and cocaine dependency. VA statistics show that it provided over 878,000 outpatient visits for drug dependence treatment. VA does not currently maintain statistics on the number of veterans who are treated for both alcohol and drug dependence, but such veterans are counted in either the drug treatment or the alcohol treatment category.

VA's total expenditure on drug and alcohol treatment in FY 1989 was estimated to be $451 million, and the total expenditure in FY 1990 is estimated to be $524 million—with the increase almost entirely due to Congress' $60 million add-on, which has also been incorporated in the base for VA's FY 1991 budget request.

Considerable time was spent at last year's budget hearing discussing the closures of and reductions in about 10 VA drug and alcohol treatment programs. I told Secretary Derwinski at the hearing that I felt it very unwise for VA to allow individual medical centers to close or reduce their substance-abuse programs as they deem appropriate as cost-saving actions. I was very pleased when the Secretary assured me that "until further notice, decisions regarding the closures or reduction of substance abuse programs will no longer be at the discretion of the individual medical centers." As far as I am aware, this continues to be applicable VA policy.

To address in part the funding shortfalls that led to last year's closures, Congress added $60 million in FY 1990 for VA substance-abuse treatment and prevention activities. To date, VA has distributed $39.9 million to the field, with 148 VA medical centers and outpatient clinics receiving funding for restoration, expansion, or initiation of substance-abuse programs. In addition, I understand that about $2.5 million will be channeled into VA's halfway-house contract program, a figure I find inadequate. I would prefer to see a much greater commitment on the part of VA to the halfway-house program. These facilities are very useful resources for care and already exist in almost every major community. I believe that the treatment and transitional housing they provide play a vital role in many veterans' successful integration back into the community after initial treatment. I also find encouraging VA's efforts to initiate innovative treatment programs, such as VA-supervised transitional residences for veterans with substance-abuse problems, including those who are homeless.

I will continue to monitor closely the spending of the $60 million in order to help ensure that it is used effectively by VA in its efforts to meet the needs of the millions of veterans who suffer from addictive disorders. I also intend to press to see that California, with anywhere from 14 to 23 percent of the national substance-abuse problem, gets an appropriate share of these extra treatment dollars.

Recruitment and Retention of Psychiatrists: VA's ability to meet the needs of veterans suffering from mental illness disabilities is directly dependent upon VA's ability to maintain a qualified corps of psychiatrists. The committee is hearing reports, with increasing frequency, of the tremendous difficulties VA faces in its competition for qualified psychiatrists. The legislation I am developing to help improve VA's ability to compete in the marketplace for qualified physicians will be designed to help overcome this staffing shortage.

PROSTHETIC APPLIANCES AND SERVICES

In each of the last 3 fiscal years, the timely provision of prosthetic appliances and services has been severely hampered by budget shortfalls within the Prosthetics and Sensory Aids Service (PSAS). According to last year's Independent Budget, at the end of FY 1987, 5,200 prosthetic orders were backlogged. This number rose to 7,550 at the end of FY 1988, a 45-percent increase in orders not filled due to funding deficiencies. A VA Prosthetic Task Force report issued in November 1988 indicated that in FY 1987 the shortfall was $6.2 million. In FY 1988, the shortfall for prosthet'ics grew to $7.4 million. In FY 1989, the shortfall was an extremely disappointing $10.6 million.

In the FY 1989 Dire Emergency Supplemental Appropriation Act (Public Law 101-45), Congress enacted a $345 million supplemental appropriation for VA Medical Care, including a $5 million add-on, initiated in the Senate at my request, specifically for the purchase of prosthetic appliances. In addition, the Senate committee on Appropriations report on this legislation (S. Rept. No. 101-40, page 40) and the conference report (H. Rept. No. 101-89, page 25), again at my request, directed VA to use any remaining funds projected to be available during the closing days of FY 1989 for the purchase of needed prosthetic appliances as well as medical equipment.

Committee staff have been assured by VA that the backlogs were sufficiently addressed by the FY 1989 supplemental. Yet, I am already hearing reports that a significant backlog is developing in the current fiscal year and threatens to grow larger than all previous backlogs. This means either that the backlog was *not* reduced with the supplemental money or that the budget forecasting capabilities of PSAS is woefully deficient, or maybe a combination of both. Many of these very questions were asked as part of the extensive prehearing questions I sent to VA, to which responses have not yet been forthcoming.

The failure of VA to ensure the timely distribution of prosthetic appliances and services for veterans whose service to their country included the sacrifice of a limb or the loss or impairment of the ability to walk or see or hear is totally unacceptable, and I will keep working to see that it does not continue.

MEDICAL AUTOMATED DATA PROCESSING (ADP) SYSTEMS

The President's budget proposes to cut Medical Care ADP activities by 105 FTE and $31.4 million in FY 1991 due to aggregate "savings" in FTE that are asserted will be gained through continued expansion of the Decentralized Hospital Computer Program (DHCP). I doubt that such cuts will replace, i.e., "save" FTE at VAMCs; it will basically serve only to allow existing staff to perform certain work functions more effectively or efficiently and to perform additional, needed functions.

In addition, the FY 1991 budget does not include funds in several areas related to medical ADP systems, despite a 1987 Comptroller General report criticizing the VA medical system for lack of ADP security and the need for VA to comply with security precautions required under Federal law. Such a program is essential in a healthcare environment using computers in its daily operation—particularly in the DHCP, which includes 800 minicomputers, 40,000 terminals, and 20,000 printers linked in a national network of VAMCs.

CONSTRUCTION

The FY 1991 request of just under $700 million for the major and minor construction accounts represents nothing less than a complete turnaround from the administration request of a year ago. This most welcome 1991 request amounts to a 44 percent increase over the administration's FY 1990 request of only $481 million. It is my strong hope that this increased level will provided the opportunity for a longterm commitment to a more realistic approach to meeting the great need for modernization, improved safety, and patient privacy in facilities across the VA system, as well as for new facilities in some parts of the country.

I am very pleased to note the inclusion in the President's budget plan of three major projects to improve the quality of, and access to health care for veterans in California. The request proposes funding of $82.5 million for seismic corrections and improvements at VAMCs at Long Beach and Martinez, as well as funding for a new VA outpatient clinic at Bakersfield. This great progress cones on top of an agreement we reached with the President in January to proceed with an emergency VA replacement hospital at Palo Alto, using fiscal 1990 emergency disaster-relief funding appropriated by the Congress in the aftermath of last October's Loma Prieta, California, earthquake.

I emphasize again my gratitude to Secretary Derwinski for his sensitivity to the needs of California's veterans and for meeting the commitment he made immediately following the October quake to give utmost priority to correcting seismic damage and deficiencies at these California facilities. I believe that the President's FY 1991 construction request is a direct reflection of that commitment.

BENEFITS PROGRAMS AND ADMINISTRATION

Compensation/DIC: On February 7, I introduced S. 2100, a bipartisan measure cosponsored by the ranking minority member and virtually the entire committee, to provide a COLA for compensation and DIC rates equal to that provided for Social Security and VA pension recipients. We cannot accept the administration's proposal, once again, to index compensation benefits to the Consumer Price Index.

I also will propose adding $26 million for interim Agent Orange-related benefits that VA would pay under S. 1153, the Agent Orange compensation bill I joined with Senators Daschle and Kerry in introducing during the last session and which the Senate overwhelmingly passed on August 3, 1989, and again on October 4, 1989, as title VIII of S. 13. I will also propose a similar addition to accommodate the cost of legislation I am preparing to add certain presumptively service-connected diseases and make other changes to benefit radiation-exposed veterans.

I have reservations about the budget's legislative proposal to cut off VA service-connected disability compensation payments for incompetent veterans who have no dependents. Under this proposal, a veterans' estate could be reduced to as little as $10,000 while the veteran is alive. The stated objective of the proposal is to prevent VA-derived estates from falling into the hands of "remote" heirs. However, the proposal would affect veterans who have a brother, sister, nondependent parent, or other relative who is a source of emotional and other support.

Veterans Benefits Administration Staffing: Department of Veterans Benefits staffing has been spread very thin in recent years and despite the backlog of compensation claims, the continuing high numbers of loan guaranty applications, the demand for increased manpower to deal with increased numbers of foreclosures and property acquisitions, and the increasing applications under the Montgomery GI Bill—the administration proposes a 266-FTE reduction in DVB staffing. The administration attributes most of this reduction to "savings" and increased productivity which it associates with ADP modernization. It is my belief that VBA simply cannot afford these proposed staffing cutbacks and that, to the contrary, the Compensation and Pension Service and Vocational Rehabilitation and Education Service need additional FTE in order to come closer to meeting appropriate timeliness standards and that the Loan Guaranty Service needs more staff for delinquency servicing.

Additional funding for loan guaranty functions is a cost-effective way to reduce foreclosures on guaranteed loans and increase receipts through improved management and disposition of foreclosed properties. VA's Houston Pilot Loan Servicing Project resulted in savings to VA of over $11 million, at a cost of just $290,000 for 10 FTE and $20,000 for equipment. That's a net savings of over $1 million for each additional employee. It is difficult to accept VA's proposed reduction in VBA staff in the face of this kind of evidence. In fact, this test project shows quite clearly the long-term costs of VA staff reductions.

Administration-proposed VA Loan Program Legislative Changes: Perhaps the most objectionable features of the President's FY 1991 budget for VA concern proposals for major changes in the VA home loan program. The President's budget proposes requiring for the first time that veterans make a downpayment—4 percent of the loan amount over $25,000—on VA-guaranteed conventional home loans. Congress created the VA home loan program in 1944 precisely to allow hundreds of thousands of veterans to purchase homes if they could make the monthly payments even when they could not come up with a downpayment. Just a few months ago, Congress enacted a law, the Veterans Home Loan Indemnity and Restructuring Act of 1989 (title III of Public Law 101-237), that encourages—but does not require—downpayments by reducing the loan fee for 5- or 10-percent downpayments. I believe that downpayments are desirable where the veteran can make one but I believe that am approach needs to be found to provide incentives for veterans to make downpayments rather than to penalize those who can't ante up. I challenge the administration to move in that direction rather than to add more requirements to the program.

The budget requests a major change in the no-bid formula. This is the formula VA uses to determine whether it is less costly to buy a foreclosed home and resell it or simply pay the VA guaranty. Just last year, VA published regulations that would have included VA's "cost of funds" in the no-bid formula—a rule that would have increased no-bids from 25 percent of foreclosures to 35 percent. A Federal judge enjoined that regulation and on December 18, 1989, the President signed Public Law 101-237, which includes a provision prohibiting VA from considering this cost. Now the administration has proposed adding a new cost to the formula that it calls "VA's average loss." VA has told us this proposal would double the number of VA no-bids—a far greater change than the cost-of-funds proposal that Congress overwhelmingly rejected just a few months ago. I have little doubt that doubling the no-bid rate would make many lenders leave the VA loan market. This is not an acceptable result.

The President also proposes raising the VA loan fee by 40 percent—from 1.25 to 1.75 percent of the loan amount—and eliminating the fee exemption for veterans rated less than 30 percent disabled and for all survivors of veterans who died from a service-connected condition. On January 1, 1990, the loan fee rose by 25 percent—from 1 to 1.25 percent—under Public Law 101-237. As the Senate author of that legislation, I want to stress that the fee increase there enacted was imposed only in exchange for granting indemnification for veterans against liability to VA in case of default. In contrast, the administration's current proposal would serve only to burden veterans further without any benefit in return.

These VA home loan proposals, if enacted, would significantly undermine a 46-year-old program to which Congress overwhelmingly reconfirmed its commitment just 3 months ago. I will oppose all such changes in the fundamental nature of this important veterans' benefit and very much doubt that we will have time for committee hearings on these kinds of proposals.

VA's proposal to eliminate the problem-riddled manufactured housing program appears to be another example of overkill. Instead of proposing innovative ways to make the program do the job Congress intended, VA has decided to throw the baby out with the bath water. I share the concern about this program's large losses, but I find it difficult to believe that we cannot salvage some aspects of a program that may be the only channel for home ownership for certain, deserving veterans.

I am pleased to note one piece of good news from the administration concerning the VA home loan program. Secretary of Housing and Urban Affairs Jack Kemp called me yesterday to tell me that HUD will raise the Government National Mortgage Association's cap on VA-guaranteed loans to $184,000 to accommodate congressional policy expressed in a provision I authored in Public Law 101-237 to raise the maximum VA guaranty to allow loans of up to $184,000. GNMA's virtual monopoly on the VA secondary mortgage market had made lenders unwilling to make these higher-value loans until yesterday's action by GNMA. This action will give to veterans in higher cost real estate markets the ability to obtain no-downpayment VA home loans.

VBA Automated Data Processing: The administration request of $69.2 million for ADP Systems Management program in VBA represents a significant increase of $23.3 million over the request of a year ago. The corresponding 437-FTE request for ADP in FY 1991, however, would achieve a staffing increase of only 8 FTE over current levels. This FTE increase is inadequate, in my view, to contribute measurably to easing the enormous and still-growing backlog in benefits claims processing. I am pleased to note that the administration's ADP request will include funding to support both the Twelve-Point Plan as well as current systems; at the same time, funding for several short-term initiatives requested by VA was not approved by OMB.

NATIONAL CEMETERY SYSTEM

A total of 113 cemeteries, located in 39 States and Puerto Rico, are administered by the National Cemetery System. Since the establishment of the NCS system in 1973, VA estimates that approxmately 721,000 decedents have been interred in national cemeteries and approximately 4.4 million headstones and markers have been furnished to mark graves. For FY 1991 alone, VA estimates that over 63,000 interments will take place—an increase of more than 4,700 over FY 1989.

The FY 1991 budget recommendation for the National Cemetery System includes a most welcome $6.5 million and 52 FTE increase over FY 1990 levels, for a total operating budget of $54.8 million and an average employment level of 1,276; $2.2 million of the proposed $6.5 million increase would go toward reducing the current $7 million equipment backlog.

The National Cemetery System is entrusted with providing and maintaining a dignified final resting place for those who have proudly and honorably served their Nation. Thus, I have become increasingly concerned with reports that current very stringent NCS funding levels are preventing the proper maintenance of a number of the cemeteries under its care. Funding shortfalls have forced a shifting of resources away from equipment and maintenance in order to meet "must-pay" obligations such as payroll. VA estimates that many of NCS 8,000 pieces of equipment have been extended well beyond their normal life' expectancy, accounting for the $7-million replacement backlog.

Due to a shortfall in the current fiscal year's operating budget, the Director of NCS was forced to make several cost-cutting decisions, one of which was to limit watering drastically throughout the West. The result has been dying grass and brown landscapes, most notably for me at the Fort Rosecrans National Cemetery in

San Diego, California. The continued deterioration of our national cemeteries would be an affront to the brave men and women buried in them and must be prevented.

GENERAL OPERATING EXPENSES

General Counsel: The FY 1991 budget request for VA's Office of General Counsel includes an increase of 43 FTE and $4.5 million above the FY 1990 level. According to the budget submission, the personal service increase of $3.9 million is needed primarily for the General Counsel's office to carry out new responsibilities resulting from the enactment of judicial review provisions in Public Law 100-687. This law created the U.S. Court of Veterans Appeals and assigned the General Counsel responsibility for representing VA's interests before the Court. I have received no indications that this amount will be insufficient for General Counsel to carry out its duties in FY 1991.

Board of Veterans Appeals: The FY 1991 budget request for the Board of Veterans Appeals (BVA) includes an increase of 16 FTE and $2 million above the FY 1990 level. According to the budget submission, the proposed increase in FTE would enable BVA to reduce its average response time from the current FY 1990 estimate of 191 calendar days to an FY 1991 estimate of 175 days. Such an improvement would be welcome, but it is not yet clear to me how it can be attained with such a small FTE increase.

DEPARTMENT OF LABOR VETERANS' AND TRAINING SERVICE

Last year, President Reagan's budget request adhered to the statutory mandates, which I authored in the Senate in section 4003A and 4004 of title 38, requiring the Department of Labor annually to make available in each State an amount sufficient to support one Disabled Veterans' Outreach Program Specialist (DVOP) for every 5,300 disabled and Vietnam-era veteran residing in that State and an amount sufficient to support the assignment of 1,600 full-time Local Veterans' Employment Representatives (LVERs) and the State's administrative expenses associated with the assignment of that number of LVERs.

This year, the administration's FY 1991 budget request, calls for DVOP and LVER funding levels more than 6 percent below those required by these statutory funding formulas, resulting in staffing levels that would be more than 8 percent below congressionally mandated levels. It is very disappointing that the administration attaches such a low priority to veterans' employment and training needs and for disregarding the clear statutory mandates.

A great disappointment is the budget request of only $829,000 for the National Veterans Training Institute (NVTI), a more than 61 percent drop from FY 1990 funding of $2.145 million. This year's grossly inadequate funding request comes in spite of the fact that the Department of Labor has recently contracted with the University of Colorado for the provision of NVTI training at a total cost to DoL of $2.7 million. What's more, whereas the budget request calls for only 500 training participants in FY 1991, a 71-percent drop from the FY 90 level of 1,700 participants, the contract agreement with the University of Colorado provides for the actual participation of between 1,800 and 2,000 trainees during FY 1991.

The administration's budget calls for $225,000 in funding for the Department of Labor's Transition Assistance Program (TAP) to implement the provisions requiring a pilot program of employment and training counseling services to separating servicemembers, which I authored last year in Public Law 101-237. The $225,000 figure is clearly not adequate for the program and would necessitate diverting the balance of the needed funding from the title IV-C discretionary fund.

The FY 1991 request of $8.863 million for veterans' programs out of the Labor Secretary's title IV-C discretionary fund represents a 5 percent decrease from FY 1990 funding of $9.345 million. Eighty percent of FY 1991 funding is already earmarked for State distribution. Of the remainder, $1.4 million is proposed to be used to meet part of the shortfall in funding for the NVTI and $225,000 is targeted for the shortfall in TAP funding. This means there will be more than $1.6 million less for the kind of community-based projects title IV-C was set up to support.

All in all this is a very disappointing set of proposals. The administration is out of step with this committee, the Congress, and America's veterans when it comes to assigning priority to veterans employment and training services. As a result, the job of giving these programs the support they deserve will once again fall to the Congress this year.

U.S. COURT OF VETERANS APPEALS

Mindful that this is the first full budget cycle for the new Court, I understand that many of its needs are still difficult to pin down accurately. The Court's FY 1991 budget submission recommends a funding level of $8.9 million and an average employment level of 99. I will work to ensure that the Court has sufficient resources to carry out its most important mission.

PROPOSED REORGANIZATIONS

Proposed loan guaranty services consolidation: In a letter to me dated January 22, 1990, Secretary Derwinski reported a planned administrative reorganization to consolidate in Manchester, New Hampshire, certain VA loan guaranty operations from various offices in New England. By statute, detailed plans and their justification must be submitted to Congress for VA administrative reorganizations involving a reduction during any fiscal year by 10 percent or more in the number of FTE at a VA office or facility. Also on that day, the Secretary transmitted to Congress a draft bill to waive the statutory waiting-period requirement in this case. At the administration's request, on February 7, I introduced that bill as S. 2101 to waive the waiting-period requirement for the planned administrative reorganization involving the Loan Guaranty Division at the Togus, Maine, VA Medical and Regional Office Center. We will consider as part of today's hearing the potential impact of that proposed reorganization on the quality of loan guaranty services in the six-State New England area.

Proposed administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration: In a letter to me dated January 22, 1990, Secretary Derwinski reported a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research administration (VHS&RA) under which the existing seven regions—with offices located in Albany, NY; Durham, NC; Gainesville, FL; Ann Arbor, MI; St. Louis, MO; San Francisco, CA; and Dallas, TX would be reduced to four—with offices in Baltimore, MD; Jackson, MS; Ann Arbor, MI; and San Francisco, CA.

As I noted above, detailed plans and their justification for VA administrative reorganizations involving a reduction during any fiscal year by 10 percent or more in the number of FTE at a VA office or facility must be submitted to Congress. This requirement applies in the case of this proposed reorganization. On February 7, I introduced S. 2103, the administration's draft bill to waive the waiting-period requirement for this planned administrative reorganization. We will consider as part of today's hearing the potential impact of that proposed reorganization on the management of VHS&RA.

CONCLUSION

As I stated earlier, I am encouraged by the commitment to the VA health-care system in the President's budget request. I can assure you that I will be working hard to make the necessary improvements in the FY 1991 budget that I believe are essential to providing quality benefits and services to our Nation's veterans. Although the towering Federal deficits produced in the last decade require that we exercise prudence and restraint in making our budget recommendations for veterans' programs, we must also establish and follow reasonable priorities that treat veterans fairly. The VA budget for FY 1991 must be consistent with the Government's obligation to provide quality services and timely benefits to meet the needs of veterans and their survivors.

Again, I want to express my appreciation to all of the witnesses for their presence here this morning and their cooperation with the committee. I look forward to hearing their testimony.

PREPARED STATEMENT OF SENATOR FRANK H. MURKOWSKI

Good Morning. This morning we will hear testimony on the fiscal year 1991 budget for veterans' benefits.

The members of the committee have copies of an exchange of letters between our Chairman and Secretary Derwinski concerning the circumstances of VA's participation in this hearing. I must make it clear, before the hearing proceeds further, that I can not support our chairman in his demands on Secretary Derwinski.

The Secretary's commitment to veterans is beyond question, as are his veracity and responsiveness to the committee. And yet he, and other witnesses explaining the President's budget request, were faced with a demand that they be placed under oath.

Furthermore, Secretary Derwinski is correct in stating that he is the person responsible for selecting the officials of his Department to present and defend the budget proposals. After all, he was nominated by the President and confirmed by the Senate for the responsibility of leading the Department of Veterans Affairs. And we will hold Secretary Derwinski responsible for all VA activities as we should. It is simply inappropriate for this committee to usurp the prerogatives of the Executive Branch in carrying out its official responsibilities.

I am aware of conversations between the Chairman and the Secretary which have mitigated the situation to the extent that the hearing can go forward.

I am sure that we will hear this morning of additional services which could be provided, if we but had more money. I am sure we will hear of improvements in existing services which could be made, if we but had more money. I am sure we will hear of services which should be provided with less delay, and could be, if we but had more money.

I will listen carefully to these suggestions for additional services and resources. I have no doubt that there is more we can, and should, do to improve the programs and services that our grateful Nation provides our veterans in recognition of their services.

At the same time I must remember, and I ask the veterans of America to remember, that this budget is one of the best budgets I have seen in my tenure on this committee. Compared to other interests, veterans have always fared well in the competition for scare resources.

But, this year is extraordinary.

A $960 million increase in funding for veterans' health care is magnificent testimony to two things:

—The persuasiveness of Ed Derwinski when he goes to bat for a cause he believes in.

—The receptiveness of President Bush to sound arguments expressed on behalf of a worthy cause, America's veterans.

The budget presented to the Congress does contain elements with which I am not comfortable.

—A proposal to require a downpayment in the veterans home loan program would make a fundamental change in one of the principal tenets of the program. Never, in the 46 years of the program has a downpayment been required. The Congress restructured this program only months ago and did not take the step now requested. I recognize the benefits of the proposal. A homeowner with equity in his or her home is much more likely to care for both the home and the loan. But, I also recognize the hidden cost of the proposal. A cost which would be paid in reduced opportunity for homeownership by veterans unable to accumulate the capital needed to make the required downpayment.

—The budget request of the Department of Labor would reduce funding for staff to implement veterans' employment programs in the field.

- The Congress addressed this question when we established the formula used to determine the number of staff.
- Again, the cost of proposed budget would be borne by veterans. In this case, veterans seeking employment.
- The Nation can take great pride in the economic and employment successes of our veterans. I will certainly evaluate any arguments as to why the field professionals who helped create this success should be scaled back, but . . . at this point the burden of proof certainly lies with those who advocate scaling back this program.

I look forward to reviewing the testimony of this morning's hearing. I express my appreciation to Secretary Derwinski.

- My appreciation for the results of his extraordinary advocacy on behalf of veterans.
- And, my appreciation for VA's ongoing record of complete cooperation in providing the information the cmmittee needs to meet its responsibilities to America's veterans.

I also appreciate Assistant Secretary of Labor Tom Collin's presence to discuss the budget request for veterans' employment programs as well as the other witnesses for their effort in ensuring the committee has the benefit of their analysis and views.

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

SPARK M. MATSUNAGA, HAWAII
DENNIS DeCONCINI, ARIZONA
GEORGE J. MITCHELL, MAINE
JOHN D. ROCKEFELLER IV, WEST VIRGINIA
BOB GRAHAM, FLORIDA

FRANK H. MURKOWSKI, ALASKA
ALAN K. SIMPSON, WYOMING
STROM THURMOND, SOUTH CAROLINA
ARLEN SPECTER, PENNSYLVANIA
JAMES M. JEFFORDS, VERMONT

JONATHAN R. STEINBERG, CHIEF COUNSEL/STAFF DIRECTOR
ALAN C. PTAK, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

February 9, 1990

Honorable Edward J. Derwinski
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Ed,

This is to confirm the invitation previously extended to you on my behalf by the staff of the Senate Committee on Veterans' Affairs to testify at the Committee's February 23, 1990, hearing on the FY 1991 budget for the Department of Veterans Affairs and on two bills I introduced at the request of the Administration on February 7 to permit proposed reorganizations in the Veterans Benefits Administration and in the Veterans Health Services and Research Administration to occur prior to October 1, 1990. Enclosed are copies of excerpts from the Congressional Record describing S. 2101 and S. 2103, the Administration-proposed bills.

The hearing will begin at 8:00 a.m. in Room 216 of the Hart Senate Office Building.

In order to allow the Committee sufficient time to review your testimony before the hearing, Committee rules require that witnesses provide 40 copies of their testimony not later than 48 hours before the hearing. However, we would greatly appreciate your providing your written testimony by February 16. Please send the copies of your written testimony to:

Senate Committee on Veterans' Affairs
Room 414, Russell Senate Office Building
Washington, D.C. 20510

Attention: Claudia Kashin

To accommodate persons at the hearing interested in your testimony, please bring 25 additional copies to the hearing with you. Because of the number of witnesses scheduled to testify, and in order to leave sufficient time for questions, we ask you, as we are asking all other individual witnesses, to limit your oral statement to 5 minutes. Of course, your written statement will be printed in full in the record of the hearing.

We look forward to receiving your testimony. If you have any questions or would like additional information, please contact Michael W. Cogan or Erin McGrath of the Committee staff at (202) 224-9126.

With warm regards,

Cordially,

Alan

Alan Cranston
Chairman

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

SPARK M. MATSUNAGA, HAWAII
DENNIS DeCONCINI, ARIZONA
GEORGE J. MITCHELL, MAINE
JOHN D. ROCKEFELLER IV, WEST VIRGINIA
BOB GRAHAM, FLORIDA

FRANK H. MURKOWSKI, ALASKA
ALAN K. SIMPSON, WYOMING
STROM THURMOND, SOUTH CAROLINA
ARLEN SPECTER, PENNSYLVANIA
JAMES M. JEFFORDS, VERMONT

JONATHAN R. STEINBERG, CHIEF COUNSEL/STAFF DIRECTOR
ALAN C. [illegible], MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

February 13, 1990

Honorable Edward J. Derwinski
Secretary of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Ed,

In connection with the Committee's upcoming February 23, 1990, budget hearing, I ask that the following Department officials be made available at the hearing to provide a field perspective on, among other matters, the proposed VHS&RA reorganization and the processing of benefits claims within the Department of Veterans Affairs:

Mr. James Farsetta
Director
Brooklyn, NY, VAMC

Dr. Stanley Geyer
Chief of Staff
Seattle, WA, VAMC

Mr. Joseph Moore
Director
Chicago, IL, VAMC

Mr. Malcolm Randall
Director
Gainesville, FL, VAMC

Mr. Henry Gresham
Director
Manchester, NH, VARO

Mr. Steve Lemons
Director
Waco, TX, VARO

Mr. James Maye
Director
Los Angeles, CA, VARO

Mr. Jack McReynolds
Director
Denver, CO, VARO

Mr. Ralph Smith
Director
Roanoke, VA, VARO

These individuals are not being asked to provide testimony but rather to respond under oath to Committee questions. In the event that additional witnesses are desired to be added to this group, I will transmit a separate request that they, too, be made available for the February 23 hearing.

Thanks for your cooperation with respect to this matter. I look forward to the appearance and participation of these individuals on the 23rd.

With warm regards,

Cordially,

Alan Cranston
Chairman

cc: Dr. John Gronvall
Mr. Ray Avent

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

FEB 16 1990

The Honorable Alan Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510-6375

Dear Alan:

I am in receipt of a letter, dated February 13, over your signature, which proposes a process for presenting the Department's budget request for FY 91, and on certain operational activities of the Department. I believe the proposal to be inappropriate and counterproductive.

I am concerned that the proposal indicates an unwillingness to accept the viewpoint of the official charged with responsibility for managing this Department, as well as other key officials that will accompany me to the hearing. Instead, the letter requests the views of Department employees with lesser operational responsibilities. In effect, a process is proposed which seems akin to accepting the viewpoint of the staff of a Congressional Member, rather than the Member himself. Moreover, your staff has made contact with these individuals informing them of their required appearance prior to advising the Department that their presence was requested.

I can assure you Mr. Chairman that I, and other employees of this Department, value our integrity highly. Anything we have to say will be said honestly and forthrightly. I believe, however, that since I am responsible for the operation of this Department, I should be afforded the courtesy of deciding who testifies in support of the Department's budget and in support of certain implementing actions which I have approved.

Moreover, the request that all testimony be provided under oath is particularly troublesome to me and those officials who will accompany me to the hearing. The tone of the letter suggests that my testimony, and that of senior staff members of this Department, cannot be believed without requiring our testimony under coercive circumstances. Are we to be presumed incapable of providing forthright testimony to the Committee until proven otherwise?

2.

The Honorable Alan Cranston

During all of my years in Congress I cannot recall any instance where individuals providing testimony in connection with their proposed budget requests were asked to do so under oath. We are being asked to testify about our budget and its impact on our Department. We are not under criminal investigation.

Because of the positive personal relationship you and I have had in the past I am confident that these issues can be worked out between us or by direction to your staff.

Mr. Chairman, we have consistently shown our willingness to cooperate with the Committee as demonstrated by our responsiveness to the numerous pre-hearing questions. However, with all due respect for the prerogatives of the Congress, and notwithstanding my deep respect for you personally, I cannot agree to the request contained in the February 13 letter.

I would pleased to discuss this matter personally with you at your convenience.

Sincerely yours,

Edward J. Derwinski

EJD/rlc

ALAN CRANSTON, CALIFORNIA, CHAIRMAN

SPARK M. MATSUNAGA, HAWAII
DENNIS DeCONCINI, ARIZONA
GEORGE J. MITCHELL, MAINE
JOHN D. ROCKEFELLER IV, WEST VIRGINIA
BOB GRAHAM, FLORIDA

FRANK H. MURKOWSKI, ALASKA
ALAN K. SIMPSON, WYOMING
STROM THURMOND, SOUTH CAROLINA
ARLEN SPECTER, PENNSYLVANIA
JAMES M. JEFFORDS, VERMONT

JONATHAN R. STEINBERG, CHIEF COUNSEL/STAFF DIRECTOR
ALAN C. PTAK, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

February 21, 1990

Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
Washington, D.C. 20510

Dear Frank,

I am writing in connection with a February 16, 1990, letter I received from Secretary of Veterans Affairs Ed Derwinski regarding the Committee's February 23 hearing on the FY 1991 budget for veterans' programs and Secretary Derwinski's concerns about his testimony being taken under oath and about my request for the appearance of VA field personnel to respond to questions from Committee members, also under oath. I understand that Secretary Derwinski provided you directly with a copy of this letter.

In order to gain a better understanding of the Secretary's concerns and in an attempt to fashion an accommodation of those concerns with what I believe to be the Committee's legitimate need for accurate, forthright information in connection with our consideration of the Department's budget and the two proposed reorganizations which are proposed in connection with the President's budget, I met with Ed and Deputy Secretary Tony Principi this afternoon.

After a good, frank, and friendly exchange of views, I offered an arrangement which Ed accepted. I agreed to acquiesce in his very strong desire that neither he nor his accompanying Central Office witnesses be asked to testify under oath; indeed, my February 9 letter of invitation to him had not specified that an oath would be required although that is a fair inference from the policy I described to him in a March 17, 1989, letter (copy enclosed). Although I would have preferred that we proceed with the oath as to VA Central Office officials at the budget hearing, I believe that this result is a fair accommodation to the Secretary's strongly felt request and recognizes that problems the Committee had experienced in receiving fully accurate testimony on budget matters took place under prior VA leadership.

On the other hand, however, Ed and I agreed that the two field panels -- one of personnel from VA health-care facilities and one of personnel from VBA Regional Offices -- will be placed under oath prior to their responding to questions from Committee members. As I noted in my March 17, 1989, letter to Secretary Derwinski, this use of the oath is in no way intended to impugn any witness's integrity but rather to provide a form of protection to VA field witnesses. I feel strongly that the Committee must continue to have access to open and honest testimony from VA field personnel.

I am delighted, as I know you will be, that Ed and I were able to reach an amicable resolution of the concerns expressed in his February 16 letter. If you have any questions about this matter, please let me know. I look forward to your participation in the Committee's hearing on Friday.

With warm regards,

Cordially,

Alan

Alan Cranston
Chairman

cc: Honorable Edward J. Derwinski

Enclosure

[illegible] GRAHAM, FLORIDA JAMES M. JEFFORDS, VERMONT
JONATHAN R. STEINBERG, CHIEF COUNSEL/STAFF DIRECTOR
ALAN E. [illegible], MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

March 17, 1989

Honorable Edward J. Derwinski
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Ed,

During the Committee's March 6 budget hearing, you inquired as to the reasoning behind the taking of testimony under oath on that occasion. At the time, I gave you a brief oral response giving the background of my decision, reflected in the January 18, 1989, letters to prospective witnesses, to require the oath at the March 6 hearing. To make sure that there is no misunderstanding, I thought I would also give you a written, fuller explanation.

First, however, I would like to express, as I have on other occasions, my belief that the VA staff members who have appeared before our Committee are, as you indicated with respect to those who accompanied you at the hearing, a talented, highly professional, and honorable group of individuals. I thus want it to be very clear that the administration of the oath is in no way intended to impugn any witness's integrity.

The background of this matter pertains to representations at our Committee's March 8, 1988, hearing that the Administration's budget for FY 1989 contained ample resources for the VA to care for all eligible veterans who were expected to apply for and be in need of health care. Within a matter of months, however, it became clear that, even with the additional $215 million that Congress appropriated to the medical care account, the VA was facing a dire financial crisis in its health-care facilities in FY 1989.

In light of those developments and also to provide a form of protection to VA witnesses from Central Office and field stations in order to get completely candid, first-hand impressions of the situation, I decided to require all witnesses at our Committee's September 9, 1988, oversight hearing on the budget problems of VA health-care facilities to testify under oath. The hearing produced, in stark contrast to the overly-optimistic picture presented at the earlier hearing, a shocking portrayal of a health-care system that was experiencing its worst financial crisis and was clearly unable to provide needed care to many thousands of the veterans who would be seeking it in FY 1989. I have since received several comments to the effect that the use of the oath contributed significantly to the candor and openness that was so evident on that occasion.

Consequently, as we were planning the March 6, 1989, hearing, I decided that, for the foreseeable future, all budget hearings and oversight hearings with VA field personnel should follow that same format.

I would also note, on a related matter, that the Committee unanimously revised its rules on February 3, 1989, to require that all Presidential nominees be required to testify under oath at their confirmation hearings. I am enclosing for your reference a copy of the Committee rules.

I hope that this letter allays any concerns you or others may have had regarding the administration of the oath at our hearings.

With warm personal regards.

Cordially,

Alan Cranston
Chairman

Enclosure

cc: Honorable Frank H. Murkowski
Dr. John Gronvall
John Vogel
Conrad Hoffman
Susan Livingstone
Wilfred Ebel
Honorable Donald Shasteen

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Good morning, Mr. Chairman. It's a pleasure to be with you and the other members of the committee to receive testimony regarding the President's proposed Fiscal Year 1990 budget for veterans' programs and benefits and the two other pieces of legislation on our agenda, S. 2101 and S. 2103.

I welcome Secretary Derwinski and the other VA witnesses who are here to present testimony. I also want to welcome the other witnesses. To the Secretary and the others, I apologize that my schedule will not permit me to stay for all testimony.

I want to focus most of my attention this morning on the legislation that affects the proposed consolidation of the Home Loan Guaranty Program from Togus to Manchester, NH. But I want to briefly comment about the President's proposed veterans budget for FY 91.

There is much to be positive about in this budget. The most striking aspect is the $12.3 billion request for medical care, an increase of more than 8 percent than the funding level this year. That is the best medical care request submitted by any White House for a number of years.

Certainly, Ed Derwinski deserves much of the credit for that. I congratulate you, Mr. Secretary, for that and I know that veterans will be well served by your efforts in that regard.

But, I wish the budget was as positive for this year. As a result of sequestration and a miscalculation of personnel costs, it's my understanding the medical care shortfall for this year is around $250 million. Ed, I know the Chairman and the other members of the committee want to work with you to reach a solution to the present budget shortfall.

As good as the medical care request is, the proposed changes to the home loan program are bad, particularly the proposal instituting a downpayment requirement for the first time in the 46-year history of this program.

I know Senator Cranston has made no secret of his position on several of the home loan proposals, so there is no reason for me to belabor my concerns with them

Mr. Chairman, I know you submitted written questions to VA prior to this hearing. There is a great deal of ground to cover during this hearing, so in the interest of time, I will also limit my statement this morning to the proposed waiver legislation affecting the home loan program at Togus.

Secretary Derwinski, I am deeply concerned about your proposal to consolidate loan guaranty operations from Togus to Manchester, NH, and the draft legislation that would waive the "notice and wait" provisions of section 210(b), title 38, United States Code.

I have several concerns. I want to bring them to your attention at this hearing so there will be no misunderstanding between us as to the source or nature of my concerns.

First and most pressing is the impact this consolidation would have on the effectiveness of the loan guaranty program in Maine.

After I first learned of the VA proposal last year and did not hear any protests or objections from constituents or the affected industry groups in Maine, I assumed they had accepted VA justification and plans for the consolidation.

To prepare for today's hearing, I had my staff send copies of the VA plan and justification and the draft waiver bill to the:

Maine Association of Realtors; Maine Bankers Association; Maine Homebuilders Association; Mortgage Bankers of Maine; and Savings Banks Association of Maine.

When my staff began checking with Maine banks, mortgage companies, realtors and homebuilders these groups all said they had no idea a consolidation was being considered much less that is was so close to implementation.

Representatives from several of those groups have now responded to my inquiries and said they could not support the consolidation at this time, citing possible problems associated with moving to Manchester, especially in securing timely service.

It's clear that the Maine businesses directly involved in the loan guaranty program don't feel they've had adequate input into the proposed consolidation and at this point oppose it.

At the very least I don't think the consolidation should be moved forward until these groups and affected veterans have had the full opportunity they deserve to comment on the proposal and to have VA respond.

The second concern has to do with the overall condition of the economy in New England. I know that you and your staff feel strongly that this proposed consolidation will improve the home loan guaranty operation in the region. I want to make sure the region's changing economic situation are being factored in.

Aside from the substantive issues involved with consolidation I want also discuss with you the need to talk with the White House about moving all Federal services and personnel for northern New England into New Hampshire.

This is the second proposed consolidation of Togus functions to Manchester.

Two years ago, when the Government Affairs Committee was considering the VA cabinet-status legislation I remember quite clearly a discussion I had with one witness who was opposing a provision in the House-passed bill that required a VA regional office in every State.

He was arguing the provision limited management flexibility for the Secretary. I said many of us in rural States felt the need for such language.

In fact, I said that if some officials in OMB had their way there wouldn't be a Federal office north of Boston. It seems now the line of demarcation is Manchester.

As if the two proposed consolidation weren't enough to get my attention, I was also struck by the President's budget proposal for the U.S. Forest Service's Research Unit at Orono to be closed and its personnel relocated to Durham, NH.

By way of background, Maine is the most-heavily forested State in the Nation and the forest products industry is the largest component of Maine's economy. For 5 years, Senator Cohen and I have tried to work with the Forest Service on securing adequate funding for that unit. We have not asked for funding solely for the sake of building up this unit. We have made clear on every instance that we wanted to work together with the Forest Service in funding the Orono unit as part of a integrated regional approach to forest research generally.

Unfortunately, the President's budget proposes closing the unit entirely and relocating personnel to Durham, NH.

While my concerns with the loan guaranty consolidation are based on substance, I don't feel I can acquiesce to waiving the provisions of section 210(b) while the proposal to close the Orono Research Unit is still be considered by the administration.

I know you understand my situation, Ed.

But, let me be clear that I am more than willing to work with you in resolving all of the concerns I have addressed here.

After all, we share the same goal. Improving the delivery of VA services to those who have earned those services while in the armed services of this Nation.

PREPARED STATEMENT OF SENATOR SPARK MATSUNAGA

Thank you, Mr. Chairman.

Aloha and welcome, Mr. Secretary and distinguished witnesses. As always, I am delighted to be here to listen to testimony on one of our major national priorities, the care and protection of the Nation's 27 million veterans and their families.

Mr. Secretary, allow me at the outset to commend you for the outstanding job you have done in securing one of the most promising VA budgets in a decade, which, at $30.4 billion, is $1.2 billion more than appropriated for the current year. I think that all the members of this committee are especially pleased by the 8 percent increase in the health-care account, which constitutes the bulk of the increase.

As you have stated, the size of the VA budget is attributable in large part to the Department's elevation to cabinet rank. But permit me to State for the record that veterans fare as well as they do in the FY 1991 budget because they are fortunate to have you as our first Secretary of Veterans Affairs. It is obvious that your deep commitment to veterans and your substantial experience and skill are a formidable combination in the annual budget battles.

Having said all this, I do want to State that I have some serious concerns about the proposed budget. While it is a remarkable document in these tight fiscal times, the proposed veterans' budget still falls short in some important areas.

For example, it does not address the $250 million shortfall between the current year's health-care funding and the proposed FY 1991 budget. Veterans all over the country are facing serious health problems; it is too much to ask them to wait a year down the road for relief. At the behest of Chairman Cranston, I and many other Senators signed two letters to the President on this matter. I ask you to join us in urging the President of the necessity of submitting an emergency VA health-care supplemental that will bring FY 1990 spending levels up to those proposed for FY 1991.

Another drawback is that the budget is deficient in certain priority areas, such as medical and prosthetic research and post-traumatic stress disorder (PTSD) treatment. As you know, research not only provides new, improved treatment techniques, but also is an essential element in maintaining consistently high quality care in VA medical centers and clinics as well as in attracting and retaining the best qualified personnel. It is somewhat contradictory that this disincentive to recruitment and retention occurs in the same budget that proposes a 3.5 percent pay raise, a special pay increase for physicians, and pay reform for nurses.

With regard to PTSD treatment programs, I am informed that the budget contains no increase over FY 1990, despite the fact that the National Vietnam Veterans Readjustment Study, released in December 1988, revealed that only 20 percent of Vietnam veterans with PTSD received treatment from the VA. What of the fate of the remaining 80 percent? Without a major increase in PTSD program funding, how are we to treat these 800,000 potential clients? I have a special interest in this matter because of the unusual incidence and prevalence of PTSD among Hawaii veterans, particularly those residing on the neighbor islands.

Also extremely problematic are the loan program initiatives to increase the loan origination fee by 40 percent and to require a 4 percent downpayment of loan amounts over $25,000. Since WWII, the Nation has promised all veterans a fair opportunity to share in the American dream of home ownership. That dream should not be tarnished by proposals that first only nibble at, and then take larger and larger bites out of, loan entitlement programs.

Finally, I am concerned by the proposed administrative restructuring of the Veterans Health Services and Research Administration. I fully agree with you on the need to make major changes in the health-care bureaucracy—and with your right to manage the Department as you see fit. I fervently hope that your reorganization will lead to rationalized and uniformly implemented health-care policies. I also hope that the administrative savings that result from the elimination of the medical districts and reduction of the regions from seven to four can be reinvested in direct patient care. But I do want to express certain reservations: can we be assured that any savings will go back into the VA system? If there is evidence that the reorganization is ineffectual, can we reverse the process? I hope that you will give us the opportunity to review the proposed reorganization as you consider each step.

But, Mr. Secretary, aside from these and a few other deficiencies, I must admit that I am rather impressed by the Department of Veterans Affairs proposed budget. I commend you especially and hope that you will continue to work closely with us in addressing some of the concerns that I have mentioned.

Thank you for this opportunity to speak, Mr. Chairman.

PREPARED STATEMENT OF SENATOR BOB GRAHAM

About this same time last year forty Senators wrote a letter to the President in support of a $635 million supplemental appropriation for the Department of Veterans Affairs. Health-care providers across the country were unable to meet veterans' needs. A number of individuals testified at a hearing I held in Orlando that they and their fellow veterans were being denied critical health care services.

This year we are asking the President for another supplemental appropriation. But this time we are only asking for $252 million.

Why the difference? There are a number of factors, but one of the most important is that for the first time in years, the needs of the VA are being heard by the Administration.

This is especially clear when you look at the fiscal year 1991 budget request for the Department of Veterans Affairs. This budget includes $12.2 billion for the medical care account. This represents an 8.4 percent increase of $956 million over the amount appropriated and available in the current fiscal year. While this budget request does not solve the shortfall we face in this fiscal year, it is a positive sign of support for a more responsible VA budget. I thank Secretary of Veterans Affairs Ed Derwinski for the role he has played in winning stronger support from the Administration for the VA and in developing a number of new strategies for improving the VA.

I would like to first highlight a few items for which I have particular interest and support. I am pleased that the budget request includes $10.2 million for a nursing home in conjunction with the construction of a new medical center in Palm Beach, FL. As Florida's veteran population begins to age, nursing homes are becoming an even more important link in the overall health care service system. In the fiscal year 1990 appropriation measure for the VA, Congress recognized the need for this nursing home and included $400,000 for the project.

I am also pleased that the VA budget includes $12 million for construction of a parking garage at the Gainesville VAMC. Relocation of the current parking facility must occur before work can go forward on construction of a long-term psychiatric facility. Congress has also endorsed this project through the appropriation of design funds.

I had hoped the VA budget would include construction monies to follow-up on the design funds appropriated last year for upgrading and expanding the Tampa VAMC spinal cord injury unit. The need to double the nursing home at the Lake City VAMC persists, as well. I look forward to working with the Secretary on both of these needs.

Another item on the Secretary's agenda which I endorse is the proposal for a commission to review the mission of the major VA medical facilities. America's veteran population has changing needs. We must rechannel limited resources to meet the changing medical needs of veterans and to keep-up with the changing demographics of the veteran population.

I am concerned, however, with the proposed reorganization of the Veterans Health Services and Research Administration. Currently there are 27 medical districts and 7 regional offices which report to the D.C. central office. This budget would reduce the regional offices from seven to four completely eliminate the medical district offices.

Our office receives numerous complaints, as does the Secretary's, about inconsistencies in VA health care across state lines. The input of the district and regional VA offices is very helpful in tracking down information for constituent inquiries on this and other issues.

Secondly, the regional and district offices have intimate knowledge of the needs of individual facilities in their jurisdiction and of the larger communities they serve. In my State in particular, the district office is a critical link in the network of medical facilities, veterans services organizations, the Florida Department of Veterans Affairs, the VA and Congressional offices. The district office provides information crucial to policy makers.

Mr. Chairman, I am submitting for today's hearing record a number of statements from Representatives and Senators who share these concerns.

We understand the Secretary's interest in achieving cost-savings in the administration of the VA and his interest in streamlining the sources of information coming into the headquarters. However, we fear that the individual medical facilities and individual veterans will lose their voice in policy making if their only liaison is shared with numerous other States.

For example, in the proposed district three as outlined in the Secretary's plan, 45 medical facilities and 71 outpatient clinics would be competing for the attention of one office in Mississippi.

In addition, the proposed region three would have oversight for the care of 5.9 million veteran outpatients and 350,574 inpatients. In total, the proposed region three outnumbers the veteran population of the proposed region four by over 2 million.

Congress should not micromanage the" VA, but this proposal goes too far in eliminating important administrative offices. I am hopeful that the Secretary will reconsider the size – in terms of veteran population – and boundaries of the new regions. I also encourage the Secretary to maintain, perhaps in a less formal way, the medical district structure for planning and information-gathering purposes.

PREPARED STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and members of the committee, I am pleased to appear before you today to discuss the President's 1991 budget proposal for the Department of Veterans Affairs.

Mr. Chanman, I applaud the President's proposal. The VA request of $30.9 billion is not only the largest budget ever proposed for veterans' programs, but it increases the VA medical care budget $1 billion, by more than 8 percent. In today's era of fiscal constraints, that is nothing short of remarkable.

The 1991 request reflects the President's vision and his recognition of the debt we owe our Nation's veterans and their families. It is a tribute to veterans in this country and the organizations which represent them here in Washington. And it shows the true meaning of Cabinet status and direct access to the President.

Mr. Chairman, this is a new decade and it is a new era in veterans' affairs. There are changes all around us at home and abroad. It is time for the VA to change too. We cannot stagnate. We must move forward.

First, we will be more responsive to the needs of our clients. We are a service-delivery organization. We exist for the sole purpose of serving our clients. We will improve the quality of our services and the management of our programs. Without good management, we cannot provide good service.

In health care, the task before us is clear. Medicine has changed, technology has changed and our veterans have changed. Our veterans are older and that means they have more illnesses requiring inpatient hospital care. That also means they have more chronic illnesses and need to be cared for in outpatient clinics or the community. Mr. Chairman, we will maintain a strong acute-care system, but we will also put more emphasis where it is needed in extended care, in outpatient clinics and long-term care facilities.

This is why our realignment commission is so important. Our health-care system has not been reviewed as a whole in 25 years. It is our responsibility to gear our system to the needs of the people we serve and provide state-of-the-art care in the most humane way possible. That means offering a complete set of services from preventive health care to hospice care. We will care for veterans who are ill, and also do our part to keep veterans well and out of the hospital. To those who are terminally ill, we will provide the most compassionate assistance available today.

Mr. Chairman, in the veterans' benefits arena some changes are in order as well. Most particularly, the current statutory policies governing our loan guaranty program are of great concern to me. For fiscal years 1989, 1990, and 1991 the Loan Guaranty Revolving Fund will require over $1.5 billion in appropriations to offset losses due to foreclosures, despite our efforts to limit them. Therefore, it is appropriate to review all the policies of our loan guaranty program to preserve its integrity and solvency, so this benefit will continue to be available to veterans in years to come.

We have proposed that veterans make a 4 percent downpayment on GI home loans over $25,000, with the first $25,000 being exempt. I believe this proposal is a responsible one. It is standard practice to require downpayments of up to 20 percent on conventional loans, and it is well known that foreclosure is less likely when borrowers make a downpayment. When homeowners are having financial difficulty, the equity provides an extra incentive to make every effort to keep the home.

For VA's average loan of $80,000, the proposal would require a downpayment of $2,200, a very modest requirement if it helps even a few veterans avoid the loss of both their loan benefit and their home through foreclosure. Additionally, the burden of saving the downpayment will be reduced by other administration proposals designed to promote private savings. Thus I believe the proposal for a modest downpayment will not impose a great hardship, and will better protect veterans' interests and those of the Government and its taxpayers.

We have also proposed to eliminate the VA Manufactured Home Loan program, primarily because of its extremely high foreclosure rates. This situation has adversely affected the financial solvency of the loan guaranty program and resulted in substantial debts for veterans whose loans were liquidated and homes repossessed. On balance, the Manufactured Home Loan program is not providing a viable benefit to veterans, despite our efforts over the years to improve the program. Its continuation is no longer justified.

Mr. Chairman, along with our proposed programmatic and legislative changes, we will continue to manage our resources more efficiently. We believe strongly in implementing management reforms where necessary.

Our first major management initiative was to reorganize the field structure of the Veterans Health Services and Research Administration (VHS&RA). This effort phases out 27 medical districts and reduces 7 medical regions to 4. This will achieve more uniform management practices throughout the system, improved communication between VA headquarters and individual facilities, and the elimination of the duplication of activities by medical district and regional offices. We believe this new structure will promote a more efficient and more accountable organizational structure for our health-care system.

Second, over the last several years, loan guaranty workloads in New England have declined to the point that having a fully stafted Loan Guaranty Division at four regional offices is uneconomical. An extensive study to determine how to provide the best service to New England veterans concluded that loan guaranty operations at the Boston, Hartford, Togus, and Manchester VA offices should be consolidated into one division, to be located at Manchester, NH.

Provision of good, timely service was a primary consideration in this decision. Mr. Chairman, I am convinced that a properly staffed consolidated office will process the workload more efficiently than the current arrangement, without any reduction in service to veterans homebuyers.

Finally, we intend to pursue additional management reforms in all our organizations in the coming months. This year, we will take steps to improve the structure within our central headquarters here in Washington. Our goal is to improve the efficiency of our line and staff elements, and, thereby, improve our ability to provide quality and timely services to our clients.

I will now summarize the 1991 budget request for the VA, highlighting the budget issues for each of our major programs.

BENEFIT PROGRAMS

COMPENSATION

The 1991 budget requests $11.3 billion, under existing law, to provide compensation payments to nearly 2.2 million veterans and 323,700 survivors. The 1991 funding request reflects the full year impact of the 4.7 percent compensation rate increase provided to all recipients effective December 1, 1989.

Again proposed is legislation to index compensation benefits to the annual change in the Consumer Price Index. Enactment of this proposal would guarantee that all compensation recipients are provided a full and timely cost-of-living adjustment. It is currently estimated that the first such "automatic" cost-of-living adjustment, effective December 1, 1990, will be 3.9 percent and cost approximately $347.3 million.

In addition, legislation will be proposed to place a limitation on the estates of incompetent veterans with no dependents. Under this proposal, benefit payments would be discontinued when the assets of a veteran reach $25,000, resuming when assets are reduced to $10,000 until the $25,000 limit is again reached. This will ensure that remote heirs of incompetent veterans do not inherit large sums of veterans benefits. This proposal is expected to save $170.7 million in FY 1991.

PENSIONS

The 1991 budget submission includes an appropriation request of $3.8 billion for the pensions account. This amount will provide payments to approximately 1.1 million eligible recipients. The 1991 caseload estimate is 46 thousand below the 1990 estimate. The caseload reduction reflects a declining trend in this program, in part due to increased mortality among eligible recipients that exceeds new accessions to the rolls. Although it is anticipated that the number of veterans age 65 and older will increase during this decade, improvements in retirement benefits as well as other income sources will also contribute to the continued decline in pension caseload.

This budget request includes the full year impact of the 4.7 percent cost-of-living increase provided to Improved Law recipients in December 1989, as well as an estimated 3.9 percent cost-of-living adjustment which would be effective in December 1990. The cost-of-living adjustments to eligible pension recipients, by law, are based upon the actual change in the Consumer Price Index.

Legislation will be proposed to revise the criteria for the reduction of pension paid to certain VA-institutionalized veterans. Pension reductions make it difficult for these veterans to meet continuing monthly obligations (such as rent) during institutionalization. This ultimately hampers efforts to place these veterans back into the community. This proposal would increase the period to the completion of 12 months before a pension would be reduced. It would allow up to $10,000 of withholdings to be returned to the veteran upon release from VA care.

Also, legislation will be proposed to allow the VA to have access to Internal Revenue Service information for the purpose of verifying the income of pension beneficiaries. This proposal is expected to save $61 million in FY 1991.

BURIAL BENEFITS AND MISCELLANEOUS ASSISTANCE

For 1991, an appropriation of $155.5 million is requested to support operations in the Burial Benefits and Miscellaneous Assistance appropriation.

This request will provide for an estimated 116,000 burial allowances to reimburse, in part, the burial and funeral expenses of eligible deceased veterans; 347,873 burial plot allowances provided when an eligible veteran is not buried in a national cemetery or other cemetery under the jurisdiction of the United States; and 290,000 headstones and markers for the graves of veterans. This request also includes funding for an estimated 390,432 flags and 40,500 graveliners.

READJUSTMENT BENEFITS

An appropriation of $502.5 million is requested to operate the programs funded by the Readjustment Benefits appropriation. This funding level will provide basic benefits to 124,800 veterans and servicepersons training under the Montgomery G.I. Bill program. The basic benefits for veterans and servicepersons will be enhanced with a $173 million transfer, primarily from the Department of Defense, which will be used to finance benefits to veterans, reservists and servicepersons. Education benefits under the older programs will also be provided to 39,975 dependents and vocational rehabilitation will be provided to 28,500 disabled veterans.

The trainee level under the older programs is estimated to be 106,000 fewer in 1991 than in 1990 due to the termination of the Vietnam era G.I. Bill in December 1989. The trainee level under the new program is expected to be 48,000 higher and will continue to increase as more individuals become eligible for benefits.

GUARANTY AND INDEMNITY FUND

In December 1989, legislation was enacted which established a new fund to finance the operation of the loan guaranty program for loans made on or after January 1, 1990, except manufactured home loans.

No appropriation is required for this fund in 1991; a Government contribution will be made to the fund each year as provided by law financed by permanent, indefinite budget authority.

Although the intent during creation of this fund was to provide a financing mechanism that would ensure the solvency of the veterans' home loan program, current projections indicate that appropriations would be required by 1995 to sustain operations. In light of that recognition, we urge that the new initiatives described below be provided under proposed legislation in this account. Combined, the new initiatives will obviate the need for appropriations well beyond FY 1995.

In order to increase veterans' equity in their properties and reduce the likelihood of default, legislation is being sought to require a small downpayment on GI home loans. Under this proposal, a veteran obtaining a loan would be required to make a downpayment at a rate of 4 percent on loans over $25,000 with the first $25,000 being exempt. Requiring a downpayment is a forward-looking proposal; there is minimal budgetary impact in 1991. However, by 1995, we estimate that the proposal will reduce obligations by $75.4 million.

Also, legislation is requested that would require all veterans receiving VA loans to pay a 1.75 percent fee except for service-connected veterans with a 30 percent or more rating. The fee may be financed. This would increase collections in 1991 by $109.5 million.

And finally, legislation is proposed to allow VA to include the losses that occur on the resale of properties in the net value calculation, when determining whether or not the loan holder can convey the property to the Government. This measure would enable VA to make more accurate determinations of the cost-effectiveness of acquiring foreclosed properties. It would reduce obligations to the fund by an estimated $5.9 million in 1991 and by $187.9 million by 1995.

LOAN GUARANTY

An appropriation of $512.2 million will be necessary under existing law in 1991 to support operations in the Loan Guaranty Revolving Fund. This request will provide funding for nearly $2.8 billion in obligations estimated for 1991. This fund continues to provide operational support for loans closed prior to January 1, 1990 as well as continuing to provide for guarantees on manufactured home loans.

Legislation is proposed which will allow the net value calculation described above under the new fund to also apply in computations pertinent to this fund It is estimated that $380.9 million in obligations would be saved under this proposal.

Legislation is also being proposed to eliminate the Manufactured Home Loan program to reduce losses. Due to the high foreclosure rates in this program, the financial solvency of the Loan Guaranty Program has been adversely affected by substantial debts incurred in this program.

Additionally, legislation is being sought which would permit a holder of a manufactured home loan to submit a claim upon receipt of VA's resale price. Any loss on the eventual resale would be absorbed by the holder and any profit would be retained by the holder.

The enactment of all legislative proposals pertaining to this fund would reduce budget authority and obligational requirements by $108.5 million and $383.8 million, respectively, for 1991.

MEDICAL PROGRAMS

MEDICAL CARE

The FY 1991 budget request of $12.3 billion for direct medical care is approximately $1 billion above the 1990 level. This is the largest dollar increase ever requested by an administration for the health care of our Nation's veterans. These resources will provide for an average employment of 194,138 or 2,337 FTEE above the 1990 level.

This budget will provide workload increases of 15,700 patients treated and 538,000 outpatient visits for an estimated level of about 1.2 million patients treated and 23.4 million outpatient visits.

This budget provides for the effect of expected inflation, the funding and staffing requirements associated with the opening of new facilities, and increased pay costs including the 1991 pay increase as well as the 1990 increase. It includes $31.4 million in proposed legislation for nurse pay reform and an additional $33.8 million and 798 FTEE under existing legislation for more nurses so that we may evaluate the benefits of eliminating nurse rotation shifts. There is also an increase of $38.6 million in proposed legislation to increase special pay for physicians and dentists. Other initiatives include $8.3 million and 205 FTEE to sustain a viable field-based quality assurance program; $4.3 million and 90 FTEE to continue pharmacy conversion of ward stock to unit dose; and $27.4 million and 428 FTEE for extended care expansion of nursing home and domiciliary care. An additional $79 million will be provided to meet AIDS and drug abuse treatment requirements.

Other significant legislative proposals will provide savings of $142 million that would: (a) expand upon current law by authorizing reimbursement from private health insurers for treating non-service-connected medical conditions of insured service connected veterans yielding $112 million in receipts and (b) require veterans who do not have service-connected disabilities and who are in the middle or higher income categories to make nominal copayments for outpatients visits ($5-$ 10), outpatient prescriptions ($3-$5) and a $9 per-diem payment for inpatient treatment generating $30 million in receipts.

MEDICAL AND PROSTHETIC RESEARCH

The 1991 budget request for Medical and Prosthetic Research is $198.5 million and 3,976 FTEE, a decrease of $14.1 million and 421 FTEE from 1990. This funding will provide continued support for ongoing programs. In 1990 a plan for a blue ribbon panel will be developed to review the research programs to insure that proposals approved for funding address the needs of veteran patients and include high priority areas such as spinal cord injuries, geriatrics, AIDS, alcoholism, schizophrenia and delayed-stress disorder.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

The 1991 request for MAMOE is $47.7 million, an increase of $2.3 million over 1990. Staffing will be maintained at the 1990 end of year level of 521 FTEE, and an increase of $1.7 million will be provided for the Health Professional Scholarship Program.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED-CARE FACILITIES

The 1991 budget request of $42 million is an increase of $651,000 over the 1990 funding level. This funding will continue VA's policy of providing additional VA-sponsored nursing home beds through less costly State and Community programs. These resources will provide 809 additional nursing home beds and 250 domiciliary beds.

THIRD PARTY MEDICAL RECOVERIES

A total of $25 million and 800 FTEE will be provided in a new account to be known as the "Third Party Medical Recoveries," to finance the billing and collection activities of third party medical recoveries. Legislation is being proposed to create this account. Another legislative proposal will allow the VA to retain a portion of collections to cover the direct program costs.

GENERAL OPERATING EXPENSES

A total of $902.5 million is requested for General Operating Expenses in 1991. This funding level, which is $90.9 million or 11.2 percent above the 1990 funding level, will support an average employment of 17,168.

The 1991 budget request for the Veterans Benefits Administration (VBA) is $605.3 million with an average employment level of 12,334 (existing legislation). This resource request is $42.5 million above the 1990 level while the average employment decreases 266. A majority of the employment reduction is attributable to savings generated by implementation of the modernization short-term initiatives.

The 1991 request also includes several initiatives that will provide for the efficient delivery of benefits to our Nation's veterans. Among these initiatives is the continuation of VBA's modernization effort. In 1991, $32.3 million is requested to support the Twelve Point Modernization plan.

In addition, VBA will maintain the employment increases provided in the 1990 appropriation bill. The additional personnel will be used to decrease the compensation, pensions and education adjudication backlog. We will continue to concentrate efforts to improve servicing delinquent GI and portfolio loans, as well as monitor major lenders through the Lenders Audit Unit, which is now officially titled the Lender Monitoring Unit.

In 1991, VBA will continue its emphasis on providing higher quality service and improving the timeliness of work. One approach will be to expand its training offerings. Several techniques will be used including courses at the adjudication academy, training seminars, as well as video tapes. These opportunities will be provided to personnel, both in and outside the VA, who are involved in the benefit delivery process.

The 1991 budget includes two other initiatives in VBA that warrant a brief discussion. First, the VA will institute net premium billing for the insurance programs. This program would allow insurance premiums to be deducted from the dividend payments, thereby reducing the transactions between the veteran and the VA. Finally, legislation is proposed to allow VA access to IRS information. This access would allow the VA to obtain accurate income information on pensioners thereby reducing the incidence of overpayments. Resources of 100 FTEE and $3.7 million are included in the FY 1991 budget proposal to support the implementation of this legislative proposal.

The 1991 budget request for the National Cemetery System of $54.8 million and 1,276 FTEE is $6.5 million and 52 FEEE above the 1990 level. The budget request provides resources for the interment of 63,100 veterans and their dependents (a 1,600 increase over 1990); the maintenance of 1.9 million gravesites and nearly 4,700 developed acres. Resources are also requested for the opening of the San Joaquin Valley National Cemetery. This cemetery is scheduled to be operational in 1992. Increased resources are also requested for the maintenance and repair and equipment replacement at our existing cemeteries. Nearly $4 million is also requested for the continuation of the State cemetery grant program in 1991.

The General Administration 1991 request of $242.5 million and 3,558 FTEE is a $41.9 million and 80 FTEE increase over the 1990 level. Over 40 percent of this dollar increase is required for the renovation of the VA Headquarters building. A total of $16 million will be used for the rental of temporary office space, office relocations, administrative as well as other support activities.

Resources will be used to expand staffing at the Board of Veteran Appeals from 406 FTEE to 422 FTEE. The employment increase, along with other productivity enhancements, will allow the VA to increase the number of appeals decided in 1991 from a 1989 level of 38,673 to 45,150. As a result, it is estimated that the processing will decline from 210 days in 1989 to 175 days in 1991.

An additional 20 FTEE will be provided to the General Counsel in order to support an increased legal workload resulting from Judicial Review. The budget request in the General Administration activity also includes $1.6 million for a Survey of Veterans (SOV IV) in addition to funding additional studies related to the 1990 census.

OFFICE OF INSPECTOR GENERAL

The Office of Inspector General requests nearly $27 million and 437 FTEE in 1991. This increase is a $5.1 million (23 percent) and 48 FTEE (12 percent) increase over the 1990 resource levels. The 1991 FTEE level of 437 represents a 20 FTEE increase over the employment level mandated in Public Law 100-527. The additional employment will enhance audit review of: mortgage lenders, quality assurance at the health-care facilities, insurance center operations, and procurement fraud.

CONSTRUCTION PROGRAMS

The President's 1991 request for the construction appropriations is $694.5 million. Of this amount, $530 million is for major projects at medical centers, regional offices and national cemeteries.

The major construction request - includes funding for three replacement and modernization projects at Detroit, MI; Indianapolis, IN (Clinical Improvements and Mental Health Behavioral Science Center); and Martinez, CA (Clinical Improvement and Seismic Corrections project). Also requested are funds for a nursing home care unit at Palm Beach, FL; a structural seismic correction project at Long Beach, CA; and three clinical improvements projects at Durham, NC; Oklahoma City, OK; and Togus, ME. Funding is also included for asbestos and other hazardous waste abatement, as well as for the setllement of contractor claims arising from projects at New Orleans, 1-,A and Pittsburgh, PA. The request will also provide funding for VA to reimburse the Judgment Fund for the payment of claims that have been made under provisions of title 31, United States Code.

Funding is also proposed for the development of additional gravesites at Fort Logan National Cemetery, CO; the relocation of the Montgomery, AL regional office to Department owned grounds; and for the renovation of the Department of Veterans Affairs Central Office building.

For minor construction, the President's FY 1991 request is $145.6 million. This is a 56 percent increase over 1990. With the attention to improving patient environment, this level of funding for this appropriation is considered essential. It is also requested that the ceiling for minor construction projects be increased from $2 to $3 million. Minor construction includes a General Administration limitation of $44.4 million.

The FY 1991 President's budget requests $18.9 million in new budget authority for the Parking Garage Revolving Fund to be used for new parking garages that are planned for construction in connection with projects at Gainesville, FL and Indianapolis, IN.

CLOSING

Mr. Chairman, in closing, we are committed to the accomplishment of the VA's mission to provide veterans the care, support and recognition they have earned in service to this Nation. Our budget request reflects this commitment. This concludes my introductory statement.

My staff and I will be pleased to discuss the details of this request and answer your questions and those of the committee members.

PREPARED STATEMENT OF HON. THOMAS E. COLLINS III, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR

Mr. Chairman and members of the committee, it is a great honor and privilege to appear before you to present my first testimony as Assistant Secretary for Veterans' Employment and Training, and to discuss the Fiscal Year 1991 Department of Labor budget as it pertains to veterans' employment and training programs.

In assuming the duties of Assistant Secretary, I was indeed fortunate to have taken on the leadership of an agency which has had an excellent history of serving veterans. For example, in the past few years the unemployment rate for Vietnam-era veterans has been on a steady decline. The unemployment rate for Vietnam-era veterans dropped from 4.6 percent in June 1987 to 3.4 percent by June 1989. While a direct relationship of our programs to that significant decrease cannot be shown, it is extremely interesting to note that services to veterans provided by our Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff improved concurrently. During the same period (June 1987 through June 1989), DVOP/LVER staff increased the rate of veterans served from only 70.3 percent of veteran applicants up to 86.6 percent.

Also, in the same period, veterans placed in jobs increased from 14 percent to 18 percent. Those improvements came about due to a variety of reasons, but primarily, because all of our DVOP/LVER staff became better trained during this period. Training of DVOP/LVER staff was provided by the National Veterans Training Institute (NVTI), permanently established by Public Law 100-323 in May 1988. From FY 1988 to FY 1989, the number of NVTI graduates doubled, from 1,435 to 2,867, and nearly all participants were DVOP/LVER staff. Consequently, existing DVOP/LVER staff are now better prepared to serve veteran applicants in an improving economy.

With that information as background, I would like to discuss our plans for the FY 1991 budget year. For FY 1991 we are requesting a total of $161,514,000 to fund 288 Federal FTE and 3,195 State positions. Those funds are comprised of $143,081,000 for grants, $17,604,000 for administration, and $829,000 for the National Veterans' Training Institute (NVTI). The FY 1991 request includes the following changes from the FY 1990 budget: grants increased slightly by $160,000; administration increased by $1,732,000, about 11 percent; and NVTI decreased significantly by $1,316,000, more than 61 percent.

A major initiative we plan to concentrate upon in FY 1991 will be the Transition Assistance Program (TAP); this program consists of two unique service delivery components, a 3-day employment workshop offered to all separating servicemembers with additional individual specialized services that will be offered to servicemembers being separated due to a service-connected disability, called Disabled Transition Assistance Program (DTAP). VETS is requesting $225,000 to fund the congressionally-mandated test pilot which in FY 1991 will expand to include an additional 21 sites within the 10-State restriction: 9 for DTAP and 12 for TAP.

Known as TAP, this cooperative effort with military service branches was begun in FY 1990 in seven States. TAP is intended to provide servicemembers who are within 180 days of separation with information and assistance regarding employment to allow them to make informed career choices. VETS anticipates that through the provision of vocational assessment and guidance services, current labor market information, and intensive job search assistance, servicemembers will be better able to obtain jobs when and if they leave military service. Additionally, such assistance and guidance is expected to shorten the postservice period of unemployment and thereby reduce expenditures for unemployment compensation for ex-servicemembers.

TAP will serve servicemembers who are separating through normal channels at military bases; beginning at 6 sites in FY 1990 with 12 additional sites in FY 1991. This program is coordinated between DOL, the Department of Defense (DOD) and the Department of Veterans Affairs. One Local Veterans' Employment Representative (LVER) will serve at each of the sites to conduct 3-day employment and training workshops.

DTAP, the disabled component, is to be pilot tested at three military hospitals in FY 1990 as a coordinated program between DOL, DOD, and the Department of Veterans Affairs. In addition to the workshop, this program will seek to provide individualized vocational guidance and career planning guidance to soon to be released disabled servicemembers. Expanding DTAP by 9 additional sites to 12 in FY 1991, DOL will identify one Disabled Veterans' Outreach Program specialist per DTAP site to provide services. DTAP may be offered in addition to regular TAP training at a particular site.

An automated tool serving as an integral part of TAP is the Civilian Occupation Labor Market Information System (COLMIS). The $225,000 requested increase for TAP in our FY 1991 budget will be used to implement the COLMIS automation initiative. Through COLMIS, separating servicemembers will be provided county level occupational outlook information; current information on available jobs, their wage rates, and employers with those job openings; and a conversion of military acquired skills to civilian occupations.

An additional $200,000 is requested to upgrade and replace existing ADP hardware purchased prior to 1987. This is necessary in order to comply with the department's ADP architecture and to ensure that all agency hardware is compatible and capable of operating the Veterans' Information Management System.

The provision of services to disabled veterans beyond the specific requirements of legislation will continue to be one of VETS' priorities. This special emphasis led to the development of the DTAP effort mentioned previously, to assist disabled servicemembers, the group most in need of such help. The staff which provides these special services are the DVOP specialists, who are especially trained for this role. Another initiative targeting disabled veterans is our involvement with International Business Machines (IBM). That program is assisting severely disabled veterans in training for and placement in quality computer related jobs.

I shall now address the three specific program activities contained in our budget. First, the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) program. The FY 1991 budget request for grants-to-States totals $143,081, 000, which represents an increase of $160,000, or 0.1 percent, over te funding level provided in FY 1990. Of that total $74,473,000 will fund approximately 1,730 DVOP positions, or 92 percent of the congressionally-mandated formula level.

We have requested a funding level of $68,608,000, which will fund 1,465 LVER positions or 91.6 percent of the mandated 1,600 positions. Budget constraints have kept the total request to an increase of 0.1 percent over the FY 1990 level.

Of course, we would sincerely prefer to maintain the DVOP/LVER positions at mandated levels. However, the requested level is consistent with our larger national objective of budgetary restraints. It should be noted that, in spite of the 1.4 percent sequestration in FY 1990, and because we were operating under continuing resolutions for most of the first quarter, we shall be able to authorize staffing of both the DVOP and LVER programs at the mandated level for the remainder of fiscal year 1990.

The second budget area to be discussed is the FY 1991 funding level requested for the National Veterans' Training Institute (NVTI). Due to budget constraints, we are requesting $829,000 to permit 500 training slots in FY 1991, which is substantially less than the $2.1 million provided in FY 1990. With existing DVOP and LVER staff already trained at NVTI during FY 1988, 1989 and 1990, training in FY 1991 will be focused entirely on newly hired DVOP/LVER staff and training for those involved in the Transition Assistance Program. Alternative funding sources and operational strategies will be evaluated since the requested amount is below minimum funding levels of the competitively-let NVTI contract which was implemented on January 1, 1990.

The third area to be covered is generically labelled "administration." We are asking for a total amount of $17,604,000 for FY 1991, including personnel compensation and nonpersonal services to fund 288 FTE agency positions. That amount is $1,732,000 greater than the FY 1990 operating budget and includes $1,119,000 for increases such as pay raises in personnel compensation and benefits; and $613,000 for increased costs of travel, rents, utilities, communication, supplies, equipment and other services.

Rather than to use some of the resources for NVTI, we decided to maintain our Federal staffing level at 288 positions for the agency in order to continue providing the full range of mandated activities and services required by law and administrative requirements. The workload performed by VETS' staff can be categorized as falling into three principal areas: (1) administration of grants-to-States for services to veterans through the Employment Service (DVOP/LVER), and oversight of overall services provided to veterans by the States, (2) administration of Title IV-C grants-to-States for training service to eligible veterans and of Homeless grants-to-States under the McKinney Act to reintegrate the homeless into the work force, and (3) enforcement of the Veterans' Reemployment Rights (VRR) program.

With regard to the Veterans' Reemployment Rights (VRR) program, within our "administrative" budget, we intend to continue to improve case processing by involving all VETS staff in efforts to educate employers regarding their legal obligations, by prompt and accurate response to VRR inquiries, and by early use of mediation and conciliation case conferencing. Additionally, recent events such as Operation "Just Cause" and the potential reduction in active military forces in response to Eastern European political changes may increase VRR workload. It is anticipated that more reservists and National Guard members will request assistance.

In conclusion, the funding level of $161,514,000 requested for our operating budget will permit Federal staff to perform all legislatively and administratively required activities and will allow the DVOP and LVER programs to operate within levels established according to budgetary constraints. The agency will focus on improving Veterans' Reemployment Rights (VRR) case processing, reducing the duration of unemployment of recently separated veterans through the Transition Assistance Program (TAP), and attacking employment problems of service-connected disabled and Vietnam-era veterans.

This budget request does not include our grants programs for training veterans under title IV, part C of the Job Training Partnership Act (JTPA) nor the Homeless Veterans' Reintegration Program (HVRP) under the Stewart B. McKinney Act. Although resources for these programs are appropriated through the Employment and Training Administration's Training and Employment Services account, administration of these two programs comprises a substantial portion of our agency's workload and is an important function for full-time Federal staff included under agency "administration." Our grants management staff must develop procedures for grant processing, establish and maintain a grant review and evaluation process, and coordinate the funding for all of the grants in both programs. For FY 1991 we are requesting $8,863,000 for the JTPA IV-C program and $2,200,000 for HVRP.

Again, I thank you for the opportunity to present our budget. I will be pleased to answer your questions.

PREPARED STATEMENT OF HON. FRANK Q. NEBEKER, CHIEF JUDGE, U.S. COURT OF VETERANS APPEALS

Mr. Chairman and members of the committee, on behalf of the Court, I appreciate the invitation to appear before you today to present for your consideration the fiscal year 1991 budget for the U.S. Court of Veterans Appeals. As with the fiscal year 1990 budget, which I dealt with as Chief Judge-designate, the Court is still somewhat tentative as to the actual demands of its docket. The Court, as yet, has not gone through a complete budget cycle, and only just recently completed its first 3 months in operation. Nonetheless, the Court has followed the organizational structure recommended by the Administrative Office of the United States Courts, and we continue to find our personnel, facilities, and equipment needs to be consistent with those commonly found in other United States courts.

At this time, it would appear that there is no excess in the fiscal year 1990 budget appropriation. I am mindful of the fact that I must revisit this issue on or before July 1, 1990, to determine any funding, not to exceed $1,000,000, found to be in excess of the needs of the Court. However, with the Court expected to attain its full complement of judicial officers in the first half of the fiscal year, and the legislative requirement that the Court fund its judicial retirement system, as well as move to permanent quarters, little or no surplus is expected the Court's fiscal year 1990 appropriation.

In considering the Court's fiscal year 1991 budget request, I would appreciate the committee's special consideration of the facilities needs of the Court. The rental space that the Court currently occupies is, at best, a sanctuary of last resort. My staff and I have been working with the General Services Administration toward obtaining better, more suitable facilities, and we remain mindful of the statutory requirement that any such space be located in the District of Columbia, and that it provide for the Court's expansion needs. In consideration of the facilities needs of the Court, the Court has no choice but to include in its budget request the estimated costs associated with the build-out and facilities modification requirements for the Court's permanent space ($1,200,000), provide for the estimated expenses associated with moving the Court facility, and the estimated expenses associated with purchasing necessary additional furnishings and equipment to support the new Court. In addition, acquisition of library resources, and word and data processing systems resources will be necessary.

Considering the newness of the Court's process and the paucity of experience since the convocation of the Court on October 16, 1989, and the fact that the Court's Interim General Rules were not effective until December 18, 1989, I am not prepared to conclude that the original estimates by the Department of Veterans Affairs as to the average annual number of cases the Court will handle are misstated. Accordingly, the growth plans for the Court's staff remain a primary objective.

The Court is finding it increasingly difficult to employ qualified specialists in the personnel, computer, and budget fields at or near the job entry pay levels. Because the Court's initial and continuing program needs are so great, the Court can ill afford to indulge in an on-the-job training exercise in these specialized fields. Lacking mentors for the entry level staff, the Court must attract more experienced personnel to function efficiently, and must be prepared to pay the price for attracting and retaining experienced staff in its leadership positions. Therefore, I have included in the fiscal year 1991 appropriations request a funding level of $4,861,000 for the Court's personnel related needs. Of this figure, $3,894,000 is requested to fund personnel compensation (about $1,000,000 of which must be devoted to the compensation of the Court's judges); $942,000 is requested to fund related benefits; and $25,000 is requested to fund the costs related to operating an employee incentive awards program.

In considering the Court's personnel-related obligations, I would like the members of the committee to be aware that the Court's request includes $319,000 to fund the expenses related to providing for the cost-of-living adjustments for fiscal year 1991. This figure includes a salary increase legislated in the amount of 25 percent of the Court's judges' respective salary rates (as last in effect before the increase). This adjustment is to be made effective in the first pay period beginning on or after January 1, 1991. It also includes the recommended 3.5 percent cost-of-living adjustment to be provided for nonjudicial staff in the first pay period beginning on or after January 1, 1991.

Additionally, the Court understands that the President previously recommended to Congress that it should delete the provisions of section 509 of the VA, HUD, and independent agencies 1990 appropriations bill. Further, the President continued this recommendation for these agencies in the 1991 appropriations bill. The Court has not explicitly requested the continuation of the exemption from section 509 for the Court's 1991 appropriations request because of the President's recommendation. However, should Congress determine that the provisions of section 509 should not be deleted from the VA, HUD, and independent agencies 1991 appropriations bill, the Court respectfully requests that the provisions of section 509 be suspended for application to the Court's appropriation in fiscal year 1991. This request is based on the difficulty and uncertainty of estimating the Court's personnel compensation and benefits costs, its responsibility to fund the Court of Veterans Appeals retirement system and its facilities and equipment needs 1 fiscal year in the future, after only 3 months of operation.

In conclusion, I appreciate the opportunity to appear before the committee to speak regarding the resource needs of the Court, as it continues the work begun by Congress of providing judicial review of the claims of our country's veterans. The Nation should be grateful Congress and the President have given the Court the opportunity to provide veterans their first opportunity for judicial review. It is both a challenge and an honor to be a part of forming the U.S. Court of Veterans Appeals. I am happy to answer any questions the committee may have regarding the Court's appropriation, here if possible or by subsequent communications.

PREPARED STATEMENT OF ROBERT L. JONES, NATIONAL EXECUTIVE DIRECTOR, AMVETS

Mr. Chairman, members of the committee, AMVETS thanks you for the opportunity to testify as one of the representatives involved in the independent budget proposal.

January 29, 1990, President George Bush unveiled an unprecedented $30.9 billion FY 1991 budget for the Department of Veterans Affairs (DVA). While most budget watchers were predicting that discretionary programs would suffer immense shortfalls, the administration, we feel, took everyone by surprise by increasing the Medical Care Budget Authority some 9 percent. We must admit it was a pleasant surprise and a far different approach to adequately funding veterans' programs than we have seen far the last 8 years. But because of the erosion built into the budget process over the last decade, even this unprecedented $30.9 billion FY 1991 budget reminds one of the little boy with his thumb in the dike wondering if his efforts will save the village until sufficient help arrives.

It has become accepted policy to inflate the budget and base many increases on ill-advised legislative proposals which are far too often shortsighted and not in the best interest of veterans. One such proposal is to require the veteran to make a 4 percent downpayment on loans over $25,000 with the first $25,000 being exempt. Also proposed is an increase in the funding fee requirement from the current 1.25 percent to 1.75 percent. The combined effect of proposed legislation for the loan guaranty program reduces the appropriation from $512.2 to $403.7 million. AMVETS feels confident the Congress would never allow most of these legislative initiatives to become law. If the proposed legislative savings are therefore unattainable, the only question left to ask is: Is this a realistic budget in this areas?

There are other cost saving proposals outlined in the benefit programs areas, some of which AMVETS would not oppose and perhaps could endorse after they have been ironed out. However, one proposal we will continue to oppose is the automatic indexing of compensation and pension payments to the annual change in the Consumer Price Index (CPI). As in the past, AMVETS is unwilling to remove the annual review and assessment of veteran needs by the Congress provided for under the current system.

A major concern with respect to the administration's FY 1991 budget proposal may be found in the General Operating Expenses appropriation level. Incorporated in this account are the staffing (FTEE) levels for the Veterans Benefits Administration (VBA) and, while the appropriation will increase some $42.5 million to $605.3 million, the overall staffing will decrease by 266 employees. It is expected that 100 FTEE will in fact be redirected within VBA, thus reducing only 166 FTEE during

FY 1991. We find this a bit "iffy" and feel the total staffing loss will be closer to 266.

Once again we are to believe that with reduced employment levels VBA will improve the quality and timeliness of claims while at the same time reduce their backlog of some 600,000 pending claims.

The $1 billion increase for health-care funding bringing with it a total request of $12.3 billion to fund the Veterans Health Services and Research Administration was the administration's FY 1991 budget "piece de resistance." How could anyone want or expect more in this time of budget austerity and sequestration. This $12.3 billion is hoped to "get grudging acceptance" from the veterans groups and as we are not living in Utopia, how could anyone meet all their expectations.

However, let's for a moment review just where this $1 billion increase fits into a budget process that has not provided adequate levels of funding for as long as most can remember. There is currently a projected $250 million shortfall for FY 1990 that will have to be absorbed in FY 1991. In addition, $453 million will be required to meet increased payroll costs along with a $70 million package of pay reforms for health-care professionals. There is also a proposal for $25 million and 800 staff positions for the billing and collection of third party medical recoveries. The VA will also seek legislation that will allow it to keep that portion of the money they collect to recoup the cost of administering the program. Another $8.5 million and 205 FTEE will be dedicated in the area of quality assurance. While AMVETS is in full support of this proposal, we must still point out the fact that this too eats into the FY 1991 budget increase. Now using a conservative estimate with respect to equipment backlogs, we must add another $500 million which is a direct result of the FY 1989 budget.

The administration's FY 1991 budget for veterans programs and medical care is in many ways appetizing and the main course has been consumed. This budget, even with the $1 billion increase, is a bare bones budget and there is nothing left over to provide for seconds.

As you are aware, Mr. Chairman, AMVETS, the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars have once again cooperated in an effort to address the needs of America's veterans—needs based on moral as well as legal obligations this Nation has to those men and women who answered duty's call. Thus, for the 4th consecutive year we have produced an independent budget by veterans, for veterans. With the knowledge that each member of this committee has a copy of that proposed budget, I wish to point out that AMVETS totally supports the principles and guidelines used in its formulation. We further view the independent budget in toto as a legitimate alternative to the administration's proposed FY 1991 budget. You will find those areas of concern mentioned herein, explained and analyzed in great detail as well as every aspect of the overall budget.

AMVETS, as a member of this panel, will be commenting on that portion of the independent budget which pertains to the National Cemetery System.

The VSOs recommend staffing of 1,330 FTEEs for 1991, an increase of 92 over the FY 1990 independent budget recommended level. An additional $12.4 million is recommended to alleviate the current equipment backlog, normal salary increases, new equipment and maintenance funding.

In last year's independent budget, the VSOs observed that we were favorably impressed with the manner in which the National Cemetery System (NCS) is managed. We remain so. Given minimum budgetary support, there is no doubt that NCS can do it's job and do it well.

All indications, however, are that Office of Management and Budget (OMB) is succeeding in destroying the effects of NCS' excellent management. The most obvious indicator is a $6 million equipment backlog that has occurred solely because of "budget considerations."

When mowers or edgers wear out beyond economical repair, they must be replaced. There is no substitute for cutting grass; without equipment, in a short time, national cemeteries will look like "Potters Fields." The shortsightedness and meanness of this situation are difficult to fathom.

In past years, when the National Park Service was threatened with budget cuts, it would quickly demonstrate their effects by closing the Washington Monument to outraged tourists. Here the effects of budget cuts are much more profound—surviving relatives of deceased veterans who visit their graves see them overgrown and neglected. The VSOs want them to know that this is the result of a conscious budgetary policy of their Government. Under what conceivable system of priorities can this be allowed to occur?

The aging veteran population makes it obvious that there will be an increase in interments for the foreseeable future. Increased workloads will compound current problems. NCS needs additional resources and, based on their past performance, the VSOs are confident that NCS will use them efficiently.

VA plans phased development of undeveloped land in open national cemeteries and some limited expansion of existing national cemeteries through acquisition of adjacent land. With 20 million veterans expected to die between now and the year 2020, the acquisition of any surplus military space suitable for cemetery space is encouraged. VA is currently considering Fort Sheridan, IL, which would be a prime acquisition for the system.

The additional FTEEs recommended by the VSOs will provide staffing for two additional national cemeteries, located in Arizona and California, as well as proposed staff for the Presidential Memorial Certificate Program previously handled by the Veterans Benefits Administration, and generally increased workloads.

The FY 1991 independent budget includes $16.5 million in the construction budget for acquisition of land for new cemeteries, and for the maintenance and repair of existing cemeteries.

The $6 million equipment backlog should also be addressed. An additional $6.4 million is needed for new equipment and maintenance funding, supplies, and normal salary increases.

Mr. Chairman, in your letter of invitation you also requested comments on two bills introduced by you on behalf of the Secretary of Veterans Affairs.

The first bill is S. 2101, which would waive the waiting period requirement of section 210(b)(2) of title 38, United States Code with respect to administrative reorganization. This reorganization includes consolidation, elimination, abolishment, or the redistribution of functions (see section 210(b)(1)). AMVETS views this request for waiver as totally unacceptable, especially in light of the recently surfaced plans to also co-locate the adjudication function from Togus, ME to Manchester, NH. These plans effected several other Veterans Affairs regional offices. The veterans service organizations and the Congress were to be kept in the dark until these plans were finalized. We would like to point out the requirements currently found in title 38, United States Code are there to give the Congress the ability to review and protect the best interests of veterans.

S. 2103 also requests that section 210(b)(2) of title 38, United States Code be waived for a planned administrative reorganization of the regional field office of the Veterans Health Service and Research Administration. This proposal has been presented as an attempt to improve the overall management of the VA's hospital system. We have been advised that there will be little or no cost savings realized and most important, it will not effect direct patient care. Therefore, while AMVETS does not overly oppose this reorganization, we do question the need to circumvent long standing policy. We will observe this proposed reorganization with guarded optimism.

Mr. Chairman, this concludes my report.

PREPARED STATEMENT OF LARRY W. RIVERS, EXECUTIVE DIRECTOR, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the committee, thank you for the opportunity to appear before this distinguished committee to present the views of the Veterans of Foreign Wars with respect to the administration's fiscal year 1991 budget proposal for the Department of Affairs (VA). The VFW is appreciative of this committee for holding this hearing and demonstrating its continuing concern for our Nation's veterans.

Once again, the Veterans of Foreign Wars is proud to have joined AMVETS, Disabled American Veterans and Paralyzed Veterans of America in presenting to the Congress an Independent Budget for the Department of Veterans Affairs. As the name implies, our proposal is independent of the Office of Management and Budget's (OMB) influence and is based solely on what we perceive as the minimum requirements for the VA to provide the necessary benefits and entitlements our veterans have earned. Before addressing the construction aspect of the administration's proposal as compared to the Independent Budget, I would like to make several comments addressing the VFW's evaluation of the overall FY 1991 VA budget.

On January 29, 1990, President George Bush unveiled a $30.5 billion FY 1991 appropriation budget for the Department of Veterans Affairs. This budget, while showing an increase of $1.3 billion in appropriations over last year's, still falls short of meeting the needs of veterans. Even though medical care is increased by approximately $1 billion, when one takes into account inflation and the fact the VA's Veterans Health Services and Research Administration is currently experiencing a shortfall of approximately $250 million for the current fiscal year, the VA will still be hard pressed to meet its mandated and moral obligations.

While the VFW welcomes the administration's request for a million dollar increase in rehabilitation research, we are extremely disappointed in the substantial decrease in the medical and prosthetic research account. We commend the administration for including in their proposal full funding for an anticipated 3½ percent cost-of-living adjustment for all VA employees and view as a step in the right direction the administration's request for $70 million for a special pay increase to benefit physicians, dentists, and nurses within the VA system. Of course, we strongly oppose the request by the administration to require a downpayment on VA guaranteed loans and the proposed 0.5 percent increase in the indemnity fee. At this time, I will direct my testimony to the Independent Budget recommendation as it pertains to the VA's construction program.

Our specific construction program's recommendations, like other FY 1991 Independent Budget program recommendations, are based upon the strategy we believe VA must follow to meet future challenges.

Major Construction—We recommend a $666 million major construction appropriation for FY 1991 as opposed to a $530 million recommendation by the administration. Our source for FY 1991 funding projections is the VA's current Five-Year Plan. We do acknowledge this plan may not meet the priorities that an in-depth analysis of national requirements might ultimately reveal. However, we also recognize that to achieve less in FY 1991 would be catastrophic, given the limited current replacement cycle, rapidly changing clinical requirements, and the existing physical plants excessive age.

Within the $666 million total, we have recommended that Congress allocate $42 million for the Advance Planning Fund and the Design Fund; approximately $20 million more than the administration's request. These funds should permit more expeditious project planning and design. We believe a more generous allocation to the Advance Planning and Design Funds would accelerate future construction. More importantly, the FY 1991 Independent Budget seeks to ensure the initiation of a larger number of projects. We believe that underfunding in this area impedes projects by constricting planning and design. Congress' strong support for planning and design will enable VA to build more of the major construction projects it needs, once the department has set its priorities according to a rational process.

In the FY 1991 Independent Budget, we have also requested $32 million to construct new VA nursing homes. We appreciate the administration responding to the need for additional nursing homes by requesting funds to construct a nursing home in Palm Beach, FL; however, we still advocate funding that will permit the VA to construct four 120-bed nursing homes this year and in future years. The aging veteran population necessitates this annual rate of nursing construction through the 1990s. Furthermore, we assert that this rate is necessary, even if the VA complies with our recommended annual conversion of 1,000 existing hospital beds, (currently not in use) to nursing home care, plus a one-time conversion of 2,000 beds in FY 1991. It should be emphasized that we recommended these conversions in last year's Independent Budget.

Finally, our major construction proposal includes $6.3 million to acquire land for national cemeteries in states that have none. The Veterans Service Organizations (VSOs) recommended that VA purchase and construct two new national cemeteries annually until the National Cemetery System meets previously stated goals of an open-national cemetery in every State.

The remaining amount (approximately $585 million) of the major construction appropriation should be devoted to helping reduce the other five-year plan's FY 1991 medical construction requirements. We hold that the plan's recommendations are valid.

Minor Construction—The FY 1991 Independent Budget recommends a $285 million appropriation for minor construction while the administration only targets $145.6 million for this essential activity. The minor construction fund pays for smaller VA repair and update projects. The Independent Budget's recommendation significantly exceeds the FY 1990 appropriation. This reflects the VSOs growing concern about VA facilities' urgent updating and repair needs. Most VA facilities were constructed during the 1950s, and therefore update and repair needs are increasing rapidly. Earlier appropriations have fallen far short of addressing these needs.

Most of the recommended minor construction funds ($210 million) are identified for medical construction. The FY 1991 Independent Budget recommends that $42 million of this amount be designated exclusively to convert unused medical center beds to nursing home care. This $42 million allocation should be sufficient to convert 2,000 beds during this fiscal year. This proposal also reflects that the VSOs FY 1990 Independent Budget's recommended bed conversion was not accomplished. The VSOs analysis of veteran nursing home needs indicates that approximately 1,000 VA unused hospital beds must be converted to nursing home care each year for the next several years.

VA medical centers have resisted undertaking such conversions (including those that VHSRA has planned). An annual provision of $20 million for these conversions, plus a one-time $42 million appropriation in FY 1991, would end the department's claims that lack of construction funds have prevented such conversions. As earlier stated, the VSOs hold the Federal Government responsible for adequate nursing home care for the Nation's aging veterans.

We have requested modest amounts within the minor construction appropriation to support VA regional office and existing national cemetery construction projects. The FY 1991 Independent Budget recommends $5 million and $10 million, respectively, for these purposes.

Finally, the Independent Budget recommends $60 million in minor construction funds for VA construction staff (primarily within the Office of Facilities). This funding should permit staffing at current levels, and is in keeping with the VSOs' recommendation that VA take appropriate steps to establish national construction priorities, and improve construction and planning.

Parking Garage Revolving Fund—The FY 1991 Independent Budget recommends a $19.0 million allocation to this fund, which finances VA facility parking garage construction and operation. We believe that reasonable parking access is essential to patient care. We hope that, eventually, parking garage revenues will pay for new projects. Currently, however, only a few revenue-producing projects exist, so limited new appropriations are needed. Future funding requirements should diminish.

Mr. Chairman, in your letter of invitation you also requested our comment on two bills you introduced at the request of the Department of Veterans Affairs. S. 2101 would waive the waiting period requirement of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization involving the Loan Guaranty Division at the Togus Veterans Affairs Medical and Regional Office Center. The VFW has reservations and concerns with respect to the transfer of the loan guaranty operation at Togus, ME, to Manchester, NH. The VFW believes that any consolidation effort initiated by the Department of Veterans Affairs should be subjected to a thorough review as to whether that action would benefit or hinder service to veterans. We, therefore, oppose the provision to waive the waiting period as provided in S. 2101.

S. 2103 would waive the reporting and waiting period requirements for a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration. This plan would reduce from 7 to 4 the number of regional field offices. The VFW views this plan as purely an administrative prerogative of the Secretary of Veterans Affairs. We do not believe there is anything to indicate that these changes will impact on the delivery of health care to veteran patients and therefore have no objection to the advancement of S. 2103.

This concludes my statement. I will be happy to respond to any questions you may have.

PREPARED STATEMENT OF JESSE BROWN, EXECUTIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the committee, on behalf of the more than 1.3 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to have this opportunity to present our views on the budget request of the Department of Veterans Affairs (VA) for Fiscal Year (FY) 1991. In addition, Mr. Chairman, in compliance with your letter of invitation, we are pleased to offer our views on the FY 1991 budget submission for Department of Labor's (DOL) veterans' programs, the U.S. Court of Veterans Appeals (COVA), and S. 2101, and 2103 introduced by yourself, Mr. Chairman, at the request of the administration.

As you are aware, Mr. Chairman, on behalf of the VA the President is requesting $30.9 billion in budget authority in FY 1991 to administer various benefit programs and services for this Nation's 72.9 million veterans, their family members and survivors of deceased veterans.

This represents an increase in budget authority of $1 billion over the FY 1990 appropriated level. While this budget request will not fully fund the health-care needs and benefits delivery system for our Nation's veterans, this budget proposal is a significant improvement by comparison with the budget proposal of FY 1990.

Mr. Chairman, Public Law 100-527 elevated the VA to Cabinet level status. Secretary Derwinski has had a positive impact on FY 1991 budget negotiations as evidenced by this budget 2 submission. This would not have occurred without this committee—and Congress—producing legislation elevating the VA to Cabinet level status. Mr. Chairman, we commend you and members of the committee for this outstanding contribution to the welfare of our Nation's veterans, their dependents and survivors

Mr. Chairman, this is the fourth consecutive year that four congressionally chartered veterans' service organizations (VSOs) have prepared a needs-based budget document to more accurately reflect the funding levels necessary to adequately deliver benefits and services to our Nation's veterans. The Independent Budget project, a complex and difficult undertaking, became necessary due to past Office of Management and Budget (OMB) dominated budget submissions that resulted in a frightening trend of grossly inadequate delivery of health care and benefits and services for those who in the past have served in the Armed Forces of this Nation.

Congress has the responsibility to appropriate funds sufficient to ensure that health care, and benefits and services authorized for the former defenders of this Nation are efficiently delivered to those entitled to them. To do so, Congress requires a valid assessment of the needs of our veterans' community, accompanied by (in these times of scarce Federal dollars) cost-effective solutions to meet those needs. With this in mind, we respectfully direct your attention to the fourth edition of our Independent Budget project entitled "The Price of Peace—The Nation's Obligation: Correcting Budget Priorities for Veterans."

As the title of this year's Independent Budget implies, Mr. Chairman, we are gravely concerned with the low priority the delivery of veterans' health care, programs and services apparently has when it comes to appropriations.

Americans, especially those who fought for this country, are aware that our Nation's agenda properly includes such priorities as defense, science and space exploration, the environment, homeless Americans, our tragic national drug scourge, and, of course, education for the youth of our country. It seems to be universally recognized that the ability of Congress to provide budgetary support to these problems is limited, as a result of scarce Federal dollars. All of these priorities represent national problems and policy matters that require congressional appropriations.

The delivery of veterans' health-care benefits and services should not be viewed as a public policy problem, Mr. Chairman. Rather, congressionally authorized programs and services should be viewed as our Nation's obligation to veterans for serving this country as solutions to problems involving our national security interests. Many may not have chosen to go, some may not have wanted to serve, but unique among veterans is that they gave years of their lives to serve this country under conditions of personal sacrifice, hardship and danger, including combat.

Our grateful Nation years ago acknowledged their sacrifices by establishing a first-class system of postservice health care, benefits and services. From a national priority perspective, we find it regrettable that our Nation's veterans—former "solutions" to problems involving our national security interests—cannot now readily access a qualitative, responsive system of health care, benefits and services, as a direct result of a lack of budgetary support.

Take for example, Mr. Chairman, our Nation's recent deployment of forces to Panama. By all accounts, these highly trained professional servicemen and servicewomen successfully executed a very complex and difficult combat operation in the exemplary manner that has traditionally come to be expected of our Armed Forces. Fortunately, American causalities were not high; however, several young men suffered combat injuries and wounds that will render them physically disabled for the remainder of their lives.

As it relates to the issue before this committee, Mr. Chairman, what will be the response of the VA to these combat disabled veterans upon release from active duty? How will our Nation's obligation to these men and women be fulfilled by the VA? What can these wounded former defenders expect when they contact the VA in 1990 for compensation, health care, and vocational rehabilitation training?

To illustrate our point, Mr. Chairman, I would like to focus on a hypothetical veteran of our recent Panama engagement, "Corporal Jones," who sustained a severe gunshot wound injury necessitating an above-knee amputation prior to release from service.

During 1990 he will contact the VA to file a claim for benefits. When he calls the VA, he may be one of the 1.7 million veterans who are unable to access the Veterans Services Division (VSD) due to a series of reductions in Full-Time Equivalent Employees (FTEEs) and lack of budgetary support for state-of-the-art telecommunication equipment. If he is unfortunate enough to live in 24 of the 75 largest metropolitan areas of our country with no VSD counselors, he will not be able to arrange a personal visit to discuss his potential benefits. When he finally gets through and files a claim, his may be one of the 30 percent of compensation claims that requires in excess of 180 days to complete, due to staffing shortages. Since he is not working and lacks a college education, "Corporal Jones" will file an application for vocational rehabilitation training. He will find he must wait 100 days just to be interviewed by a vocational rehabilitation counselor.

Months after service, "Corporal Jones'" VA physician advises him that a new prosthesis is required to fit his stump. Upon contacting his VA prosthetic department, "Corporal Jones" finds his name on a lengthy waiting list of those needing a prosthesis, since the local VA medical center does not have the funds necessary to timely furnish its patients prosthetic devices for their service-connected disabilities.

In short, Mr. Chairman, "Corporal Jones" has been introduced to the present tate of the Department of Veterans Affairs' services delivery system—a system that lacks the resources to provide timely, meaningful delivery of this Nation's congressionally authorized benefits and services for those who were disabled serving in our Armed Forces.

Mr. Chairman, I believe you and the members of this committee will agree that just as our national defense is properly our Nation's highest priority, proper funding of the VA's health care and benefits delivery system for those who directly participated in our Nation's defense should not be less so, since the cost of providing for our Nation's veterans is an inherent part of the cost of our national defense.

Mr. Chairman, in formulating the FY 1991 Independent Budget, the participating VSOs have agreed to take responsibility for preparation of a single element of the budget. DAV's area of responsibility is the Veterans Benefits Administration (VBA). At this point we wish to present testimony relating to both the administration's FY 1991 budget request, and the FY 1991 Independent Budget recommendations pertaining to the VBA.

VETERANS BENEFITS ADMINISTRATIONS (VBA)

The VA's FY 1991 request for VBA is $605.3 million, an increase of $42.5 million over the FY 1990 appropriated level. The administration proposes a reduction of 266 VBA FTEE.

VETERANS BENEFITS ADMINISTRATION OVERVIEW

It has been a goal of our past Independent Budgets to present to Congress an objective assessment of the real needs of veterans, and to suggest cost-effective solutions to meet them. We are pleased, Mr. Chairman, to report some good news.

Past Independent Budget's have recommended that VBA revise its budget formulation methodology to incorporate veterans' needs and the resources required to provide them. We are gratified to see this year's budget submission for VBA includes a new section entitled "Assessment of Service to Veterans" for each VBA component. To the authors of the Independent Budget, this represents an acknowledgment by VA management that budget negotiations are the rightful forum to publicly identify VBA problems and debate the adequacy of the funding requested for resources to solve the problems.

We are also encouraged, Mr. Chairman, by a new direction being taken by Automated Data Processing (ADP) Management's Modernization Program that will focus on interim ADP improvements while simultaneously pursuing long-range ADP modernization, a recommendation of past Independent Budgets.

We believe also, Mr. Chairman, that VBA's creation of the National Adjudication Training Academy will go a long way in providing better service to our Nation's veterans.

These developments are encouraging, because the focus of Congress can now be directed toward the remaining and most vital ingredient needed to restore timely, qualitative delivery of benefits and services to our Nation's veterans: FTEE.

Mr. Chairman, the FY 1991 Independent Budget (and this prepared testimony) will set forth, in some detail, the problems that continue to confront the VBA, and cost-effective solutions to resolve them. Briefly stated, however, service delivery to our Nation's veterans, caused by a decade of inadequate budgetary support, is currently manifested by the following:

—Deterioration in timeliness and quality of claims adjudication;

—A backlog in compensation and pension claims that has skyrocketed from more than 167,000 in October 1987 to over 650,000 at present;

—Delays of 100 days from date of application until date of interview for those seeking vocational rehabilitation benefits;

—Nearly 1.7 million veterans unable to reach the VA by telephone for benefit information; and

—Unnecessary defaults on home loans by veterans at great cost to them and the government.

To address these problems, Mr. Chairman, the strategy of the Independent Budget is to obtain budgetary support for ADP systems management so that its newly reinvigorated ADP Modernization Program can go forward, with an emphasis on interim measures adaptable to their long-range goal. The key, Mr. Chairman, is to complement this by an infusion of 734 FTEE by a FY 1990 supplemental appropriation. The additional FTEE are needed to first stabilize and then gradually reduce the current unacceptable claims backlog.

We will outline existing VBA service delivery problems on a component-by-component basis, Mr. Chairman, and we enthusiastically invite you to compare our assessments and recommendations for these components with those set forth in the administration's FY 1991 budget submission.

COMPENSATION, PENSION AND EDUCATION (CP&E)

The FY 1990 appropriated FTEE level for CP&E service is 3,752. The FY 1991 administration budget calls for an FTEE level of 3,759, an increase of seven FTEE.

Mr. Chairman, past Independent Budgets have described in some detail the appalling state of service delivery to veterans with respect to compensation, pension and education claims. Timeliness and quality of decisions have deteriorated significantly, and a monumental claims backlog currently exists.

These problems are directly attributable to the 39 percent reduction in FTEE that has occurred in CP&E service over the past decade.

The administration's FY 1991 budget request recommends a staffing increase of seven CP&E FTEE. This is outrageous considering the following facts:

—Notwithstanding a nearly consistent CP&E FTEE level between FY 1988 (3,637) and FY 1989 (3,664), the compensation and pension claim backlog skyrocketed from 362,935 to 650,000-plus claims.

—Timeliness of claims adjudication has deteriorated significantly.

—In 1979 the VA had standards that called for 75 percent of original compensation claims to be completed in 90 days. This standard has been reduced to 50 percent to be completed within 90 days; however, cumulative 12 month data for the period ending August 31, 1989, show that only 26.4 percent of these claims were completed within 90 days. Nearly one-third (31.6 percent) required more than six months to complete, and the average completion time is now 150.9 days.

—The substantive error rate in adjudicative rating determinations has increased 30.8 percent between 1986 and 1989 as the claims backlog has grown.

—Over 50 percent of CP&E operations are not integrated with ADP operations. The CP&E staff are saddled with out-dated, labor-intensive work processes due to an ineffective ADP operation that is ill-equipped to handle current incoming claims—much less reduce the backlog.

—During FY 1989 nearly 20 percent of all CP&E adjudicative personnel were trainees (50 percent in Boston, Milwaukee, and Denver, 44 percent in Chicago, and 42 percent in St. Louis). Employees in training are able to produce only at a rate commensurate with their experience. Meanwhile, the production of senior adjudicative personnel is reduced commensurate with the time they must spend with adjudicative trainees.

Mr. Chairman, in testimony before the House Veterans' Affairs Committee February 6, 1990, regarding the administration's FY 1991 budget, Deputy Secretary Principi stated the compensation, pension, and education (CP&E) claims pending were declining, and the current number pending was 381,000.

Since this statement is at considerable variance with the C&P claim backlog figures contained within the Independent Budget, we feel an obligation to briefly outline our Independent Budget methodology to the committee.

Past Independent Budgets have reported an increasing trend of C&P backlogged cases in recent years. Our statistics are derived at by data obtained from VA.

As of August 31, 1988, the FY 1990 Independent Budget reported a pending C&P claims backlog of 362,935. The VA recently advised the House Veterans' Affairs Committee staff that their C&P pending claims as of September 30, 1988, were 368,927, a figure relatively consistent with that of the Independent Budget's.

An "Operating Performance Report—Adjudication Division—Pending End Product Workload," dated September 30, 1989, contains VA data showing total C&P claims received and completed during the previous 12 months as:

	Original claims	Adjustments/ supplementals	Ancillary	Total
Receipts	810,958	1,954,237	490,806	
Dispositions	731,946	1,755,572	458,952	
	79,012	198,665	31,854	309,531

This report confirms that C&P claim receipts exceeded claim dispositions by 309,531 during 12 months from October 1, 1988, to September 30, 1989.

By subtracting total claims dispositions from total claim receipts for the period October 1, 1988, to September 30, 1989 (309,531) and adding this figure to the claims pending at the beginning of this period (Independent Budget figure: 362,935, VA figure: 368,927), one arrives at a C&P claim pending backlog of 672,466 (IB) or 678,458 (VA), as of September 30, 1989.

This data, Mr. Chairman, illustrates, the trend of C&P claims pending is not decreasing, but rather increasing substantially; and by using either Independent Budget (August 1988) or VA (September 1988) baseline, the pending C&P claims greatly exceed the number reported to the House Veterans' Affairs Committee by Deputy Secretary Principi February 6, 1990.

It must be remembered that Independent Budget figures are taken from VA data. Additionally, timeliness and quality of C&P claims has continued to deteriorate over this timeframe. If the C&P claims backlog had substantially diminished during 1989, why wouldn't timeliness data have improved, as well?

Finally, Mr. Chairman, the administration's FY 1991 budget submission for VBA contains the following statements that directly contradict VA's stated position that both the trend and number of pending C&P claims are down from previous years.

Budget submissions of prior years have shown an increase in the amount of anticipated workload. This was due, primarily, to a large pending workload carried over at the end of each year. (DVA FY 1991 Budget Submission, Volume 4, p. 23-44) emphasis added

The declining FTEE in recent years has resulted in a backlog of cases being processed. The mounting backlogs have had the effect of increasing the pending workload at the end of each year for several years. (DVA FY 1991 Budget Submission, Volume 4, P. 23-48) emphasis added

Mr. Chairman, the narrative contained in the administration's budget submission, VA's confirmation to the House Veterans' Affairs Committee staff of 368,927 C&P claims pending as of September 30, 1988; and VA's internal operating report data showing C&P claims received exceeded C&P claims dispositions during FY 1989; taken together with their demonstrable inability to meet timeliness standards, supports our assertion that a monumental claims backlog continues to exist within VBA.

Each of our Independents Budgets, as you know, Mr. Chairman, has stressed the correlation between FTEE reduction and the erosion of service delivery to our Nation's veterans. Reading the administration's FY 1991 budget submission, one might think OMB has grasped this fact since, on Page 23-44, it is stated "More importantly, the quality and timeliness of service are dependent on FTEE."

However, Mr. Chairman, that is not the case.

The administration's FY 1991 budget request proposes a CP&E FTEE level of 3,769, an increase of only seven FTEE. Their analysis of this recommendation contains the following statement: "The 1991 level of employment will allow the VA to improve the quality and timeliness of claims processed in the adjudicative divisions."

Mr. Chairman, to say we find this incredulous is a monumental understatement. Drastic FTEE reductions have occurred throughout VBA, particularly in CP&E service over the last decade. Anticipated ADP modernization improvements to compensate for these losses have not occurred. The addition of seven FTEE to address problems of this magnitude is akin to treating a cerebral hemorrhage with an aspirin tablet. Quite frankly, Mr. Chairman, this budget request bears no relationship whatsoever to a goal of providing even minimally adequate service to veterans—much less the goal of the VSOs and the committee that service delivery to veterans be timely and accurate so that our Nation's obligation to veterans can be met.

We must State in no uncertain terms (perhaps for the benefit of OMB), that even minimally adequate service delivery to our Nation's veterans will not occur until the trend of decreasing timeliness and increasing claims backlog is stabilized, and then ultimately reversed. This will require an immediate increase of CP&E FTEE and full budgetary support of the ADP modernization programs; and an insistence that the recommended staffing level be maintained until acceptable standards of benefits and services delivery to veterans are met.

Mr. Chairman, the Independent Budget recommends an increase of 365 CP&E FTEE over the FY 1990 appropriated level of 3,752 for a total of 4,117 FTEE. This should be accomplished with an FY 1990 supplemental appropriation and we recommend this FTEE level be maintained in FY 1991.

VETERANS SERVICE DIVISION (VSD)

The FY 1990 appropriated FTEE level for VSD is 2,081. The administration's FY 1991 budget calls for an FTEE level of 2066, a reduction of 15 FTEE.

Mr. Chairman the VSD component of VA is the initial (and often the only) point of personal contact between VBA and our Nation's veteran community. The actual employment figures for VSD from 1985 through 1989 are as follows:

Fiscal year	*FTEE*
1985	2,423
1986	2,276
1987	2,200
1988	2,146
1989	2,086
1990	2,081

Fiscal Year 1985—2,423 Fiscal Year 1986—2,276 Fiscal Year 1987—2,200 Fiscal Year 1988—2,146 Fiscal Year 1989—2,086 Fiscal Year 1990—2,081

This equates to a reduction of 342 FTEE since FY 1985, consistent with a trend of overall VBA FTEE reductions during that timeframe.

Mr. Chairman, we reported in past Independent Budgets that VSD services to veterans had reached the point where 1 million or more veterans were not able to contact VSD by telephone due to inadequate staff and telecommunications equipment. VSD's service delivery goals are considered "acceptable" if 81 out of every 100 telephone calls gets through to a VSD counselor. Based on FY 1988 data, (and the fact that VSD reports meeting this level of "service") a staggering 1.7 million veterans were unable to telephonically reach a VSD benefits counselor due to blocked or abandoned telephone calls. This is simply outrageous in its implications for our Nation's veterans, particularly older, homeless or disabled veterans who have no other means to contact VA.

To further illustrate the limited access to VA by members of the veterans' community, in 24 of the 75 largest metropolitan areas of our country no veterans' benefits counselors are available for face-to-face interviews with claimants. In 1983, 198 VBA FTEE were stationed at VA medical centers to assist veterans. By 1989, this had declined to 140 while, simultaneously, the number of outpatient visits has increased from 16.6 million to 21 million. Moreover, eroded resources have curtailed VSD's ability to conduct mandated outreach programs for those most in need, since staff hours for outreach since 1985 have decreased by 40 percent.

Mr. Chairman, the administration's budget submission acknowledges that increased contact with VSD will occur in FY 1991 since our aging veteran population will require more benefits information by telephone, and VSD counselors will make direct contact with more veterans at VA hospitals as the trend of outpatient treatment visits continue to rise.

Mr. Chairman, our Nation's obligation to those who served in the Armed Forces certainly mandates accessibility to the agency charged with administering benefit programs authorized by Congress. Yet the OMB dominated FY 1991 budget submission calls for a reduction of 15 FTEE for VSD.

The Independent Budget recommends appropriations for 195 FTEE over the 1990 appropriated level for a total of 2,276 with a FY 1990 supplemental appropriation. We recommend maintaining this FTEE level in FY 1991.

VOCATIONAL REHABILITATION AND COUNSELING (VR&C)

The FY 1990 appropriated FTEE level for VR&C is 645 FTEE. The administration's budget request is for an FTEE level of 640, a reduction of five FTEE.

Vocational rehabilitation is specifically designed for service-connected veterans who experience serious employment handicaps as a direct result of a service incurred disability. For entitled veterans, this benefit would be unnecessary but for disability incurred serving their country and their inability to sustain gainful employment as a direct result thereof.

It is unfortunate for both veterans and our Nation that this component of VBA is so seriously understaffed.

It is unfortunate for veterans as they must wait 100 days from application until the date they are interviewed by a vocational rehabilitation counselor. The folly of understaffing this VBA component is exemplified by studies of successful vocational rehabilitation programs which repeatedly show the importance of starting rehabilitation quickly, before negative attitudes of unemployability become established.

It is unfortunate for our country since the successful vocational rehabilitation of disabled veterans translates to quantifiable direct monetary benefits for State and Federal Governments. A VA study of 2,407 veterans declared rehabilitated in 1987 illustrates this point.

The average annual earnings of these veterans prior to initiation of their rehabilitation programs was $2,687.53. After they completed their rehabilitation program, their average earnings were $15,047.85, an increase of 560 percent. While the benefit to these disabled veterans of once again becoming productive workers is obvious, but difficult to quantify, the direct monetary benefit to State and Federal Governments, in the form of taxes paid by the veterans studied, could be quantified:

—State tax revenues rose from $375,558 to $2,166,096, an increase of 577 percent.

—Social Security taxes paid rose from $485,814 to $2,720,136, and increase of 560 percent.

—Federal tax revenues rose from $580,914 to $4,106,573 an increase of 707 percent.

Mr. Chairman, these are not one-time revenue increases, but will occur year after year in higher rates as the veteran's income increases. Our Nation's moral obligation for providing the resources needed to deliver quick and effective vocational rehabilitation to seriously disabled service-connected veterans is obvious. Equally obvious, is that it is cost-effective for our Nation to do so.

The average caseload for a vocational rehabilitation specialist in other State and Federal vocational rehabilitation programs is 60 cases per specialist. Due to staffing shortages that have resulted from a series of inadequate budgets, the average caseload for a VA vocational rehabilitation specialist is 200 cases per specialist.

Mr. Chairman, the administration's FY 1991 budget submission projects that vocational rehabilitation claims are expected to increase by 2,153 applicants between 1990 and 1991, and states "this marginal increase would not affect the quality and timeliness of the vocational rehabilitation process." They further opine that "VBA expects to meet the same level of quality and timeliness achieved in 1989," and propose a reduction of five FTEE. That level of quality and timeliness is a disgrace, Mr. Chairman, and we find their proposal to further reduce FTEE highly objectionable.

Mr. Chairman, the FY 1991 Independent Budget recommends increasing staffing by 69 FTEE over the FY 1990 appropriated level, for a total of 714 with a FY 1990 supplemental appropriation. We request maintaining the staff level for FY 1991.

LOAN GUARANTY

The FY 1990 appropriated level for loan guaranty is 2,165. The administration's budget request proposes 2,165 FTEE for FY 1991.

Mr. Chairman, neither you nor the committee members are "strangers" to the problems associated with VBA's loan guaranty program. We wish to commend Congress, in general, and the committee members, in particular, Mr. Chairman, for passage of those provisions of Public Law 101-237 that thoughtfully created a Guaranty and Indemnity Fund for VA guaranteed loans established on or after January 1, 1990. It appears that the creation of this new fund will go a long way toward indemnifying veterans who default against liability to the VA. This indemnity feature should serve as a long-term guarantor of loan guaranty commitments made between VA and future veterans.

We also appreciate Secretary Derwinskils candid acknowledgment of VA's ineffective administration of the Loan Guaranty Benefit Program, and his commendable efforts to restructure and reinvigorate this worthwhile program.

Since 1980, the Loan Guaranty Revolving Fund has requested $2.7 billion in appropriations and $1.3 billion in transfers from other accounts. The President's FY 1991 budget includes an appropriation request of $512,200,000 for the Loan Guaranty Revolving Fund; and additional appropriations in future fiscal years appear to be a certainty.

VA has recognized, Mr. Chairman, that their loan guaranty program guidelines and policies must be tightened up to correct such problems as the issuance of bad loans, poor appraisal practices, poor maintenance of foreclosed homes and poor marketing of VA properties. We share VA management's hopes that improved national economic conditions will prevail in order to minimize the adverse impact these conditions could have on the VA loan guaranty program.

Compared to the trend in recent years, we are pleased to observe a notable decline in defaults and foreclosures in FY 1989, as well as an increase in the cure rate from 72 percent in FY 1988 to 74.27 percent in FY 1989.

We are nevertheless struck, Mr. Chairman, by OMB's continued shortsighted budget policies that fail to recognize the correlation between FTEEs and program savings. In presenting argument for a FY 1989 supplemental appropriation, the VA estimated that adding 175 FTEEs for loan servicing and 69 FTEE for property management would reduce cost to the Loan Guaranty Revolving Fund by $55.8 million, and generate $26 million in increased receipts to the fund. Thus, the addition of 244 FTEEs would have produced program savings of $81.8 million, or $335,246 per FTEE. The FY 1989 emergency supplemental appropriation provided VA 132 FTEEs for loan guaranty for a total of 2,165 FTEEs as of November 1989.

Mr. Chairman, we find it unconscionable and fiscally irresponsible that the OMB-crafted FY 1991 budget submission recommends no additional FTEEs for loan guaranty. Accordingly, the FY 1991 Independent Budget recommends an increase of 105 FTEEs over the FY 1990 appropriated level for a total of 2,270 FTEEs with a FY 1990 supplemental appropriation. We recommend maintaining staffing at 2,270 FTEE for FY 1991.

AUTOMATED DATA PROGRAM (ADP) SYSTEMS MANAGEMENT

The FY 1990 appropriated FTEE level for ADP Systems Management is 437, and the administration's budget request proposes identical FTEE resources.

Our Independent Budget states our view that improved ADP operations, complemented by an infusion of FTEEs in VBA components would be required to stop—and eventually reverse—the trend of deteriorating service to veterans, most notably illustrated in the current CP&E claims backlog. In the past, we have been critical of VBA's modernization program for its lack of, focus on interim initiatives and its lethargic implementation of long-term improvements.

Mr. Chairman, we are pleased to report what we believe to be a complete change of attitude and direction by ADP systems management. They now evidence a recognition and willingness to rapidly implement ADP interim improvements, and acquire the specialized expertise of outside contractors to assist in the development of a fully automated integrated ADP system by 1994. It is certainly none to soon since less than 50 percent of claims processing functions are presently supported with automated equipment.

Mr. Chairman, the archaic nature of ADP technology used by VA is best illustrated by the centerpiece of their interim modernization program, an excess IBM mainframe, obtained from the Treasury Department, that has seven times the computing capacity than the Honeywell equipment presently used in the VA's three regional Data Processing Centers.

We believe ADP systems management is tracking in the right direction in an effort to rapidly and effectively improve automation of VBA operations. This, complemented by additional FTEEs, will provide the long-overdue vital resources necessary to provide accurate and timely benefits delivery to our Nation's veterans.

One prevailing concern of ours, Mr. Chairman, is that OMB has, in the past, used a hint of productivity gains as an excuse to strip VBA of FTEEs and, of course, this is the major reason for the CP&E claims backlog and reduced timeliness and accuracy of claims processing.

Accordingly, we believe it imperative, Mr. Chairman, that Congress insist on full budgetary support for requested appropriations to acquire adequate state-of-the-art computer technology, in addition to increasing VBA FTEE; and that Congress equally insist that OMB not use the anticipated progression of VBA's Modernization Program as an excuse to further reduce VBA FTEEs.

For ADP Management, the FY 1991 Independent Budget recommends a staffing level of 437 FTEE.

SUPPORT SERVICES

The FY 1990 appropriated FTEE level for support services is 2,644. The FY 1991 administration's budget calls for an FTEE level of 2,391, a decrease of 253 FTEEs.

Mr. Chairman, the administration's budget request for support services starkly frames the issue before Congress.

OMB directs that actual and anticipated "modernization savings" be immediately spent (the DAV believes a better word is "wasted") on FTEE reductions. The VSOs believe that, given the sorry state of service being provided to veterans, all so-called modernization savings must be invested in a long-range plan to restore good service to veterans. Until good service is restored and expected to continue, reducing employment based on productivity gains should not be considered.

The VSOs fully expect significant productivity increases due to systems modernization. These are most likely to arrive quickly in support services activities. VBA should deploy the FTEEs VBA traditionally used to perform functions that are now or soon will be automated to perform other functions. VBA needs "across-the-board" service delivery improvements. Alternative uses of FTEEs that productivity gains will generate is limited only by VBA management's imagination.

The FY 1991 Independent Budget recommended staffing level of 2,699 FTEEs is the same as recommended in the FY 1990 Independent Budget, however, VBA management has the flexibility to allocate FTEEs to components or activities that most need them.

By investing productivity gains in improving service to veterans and maintaining the FTEE levels recommended by the IB, there is hope that good service can be restored by FY 1994. If productivity gains are squandered on FTEE reduction, there is no hope that adequate service can be restored within the foreseeable future.

IB VBA RECOMMENDATIONS SUMMARY

Mr. Chairman, the FY 1991 Independent Budget recommends the addition of 734 FTEEs for VBA over the FY 1990 appropriation, to be deployed as follows:

Veterans Services Division	195
Compensation, Pension, Education	365
Loan Guaranty	105
Vocational Rehabilitation and Counseling	69
Total	734

We recommend this FTEE level be provided through a FY 1990 supplemental appropriation and be maintained through FY 1991. We also recommend 55 FTEEs for Support Services be provided in the FY 1991 appropriation.

The estimated cost of the FY 1990 supplemental appropriation is $12.491 million (6 months) or an annual cost of $25 million—less than $1 for each of our Nation's 27.1 million veterans.

MEDICAL CARE

Mr. Chairman, the FY 1991 request for the Veterans Health Services and Research Administration (VHS&RA) calls for an overall appropriation request of $12.5 billion—an increase of $890.7 million over the FY 1990 level.

The medical care request of $12.2 billion represents a $901.4 million increase over the FY 1990 level.

The proposed medical care budget will support 193,938 FTEE, an increase of 2,837 over the previous fiscal year.

Mr. Chairman, according to the administration's budget documents which we have been provided, $453.1 million is being requested for payroll increases and $232.3 million is being requested for increased costs due solely to inflationary factors.

Thus, a total of $685.4 million is already planned to be spent for these uncontrollable factors that have little direct bearing on providing enhanced patient care to disabled veterans.

An oversimplified view of this budget request—after accounting for the myriad of increases and decreases in the various programs of VHS&RA—leads us to conclude that some $216 million is being requested for the purpose of providing enhanced medical care for disabled veterans.

Mr. Chairman, the DAV would be one of the first to acknowledge the proposed medical budget is one of the more sensible ones that we have seen in some time. Undoubtedly, this is due, in large part, to the elevation of the VA to a Department level status and Secretary Edward Derwinski's role as a Cabinet member and spokesman for veterans. We have little doubt that the Secretary forcefully pressed the case for adequate VA funding through the OMB to the White House. For his contribution, he has the heartfelt thanks of the DAV.

No one, however, should be lulled into a state of glee and complacency by the seemingly large increase in this budget request.

In our view, Mr. Chairman, this budget, if enacted, will serve to only partially respond to the effects of more than a decade of deficit funding levels for veterans' health-care needs. Although some—but surely not all—of the damage will be repaired, VA medical care is not yet in a healthy environment.

According to our information, this budget request ($12.2 billion) is some $500 million below that which the Department originally requested ($12.7 billion) for the medical care account in FY 1991.

Combined with known health-care funding shortages in FY 1990—$158 million sequestered by the balanced budget law, $94 million in cost-of-living adjustment computation errors and $65 million diverted to the war on drugs initiative—the Department's ability to provide adequate levels of quality medical care in FY 1991 is, in our view, again being placed in severe jeopardy.

Mr. Chairman, notwithstanding the proposed funding increase, the VA's ability to provide quality and timely health-care services to America's veterans—including those veterans with mandated entitlement to health-care services—will continue to erode should the administration's proposal for the medical care system be accepted and enacted in its current form.

The adverse ramifications of the VA's inadequate budgets over the years has been vividly portrayed on many different occasions by many different individuals in many different settings over the past 2 years. Numerous VA employees, including medical center directors, chiefs of staff, and nurses, together with other interested parties from various locations across the country, have presented realistic, albeit bleak, portraits of a daily struggle to simply provide the bare minimum of quality health-care services to veterans. Disturbingly, we continue to receive numerous complaints and learn of numerous situations where VA health care is being denied or rationed to eligible veterans.

Therefore, Mr. Chairman, we encourage you and members of the committee to carefully scrutinize this budget request. We believe such scrutiny will lead you to propose a realistic and meaningful funding level that will, at the very least, enable the Department to provide health-care services to those veterans so entitled by law.

In this respect, Mr. Chairman, we would further urge you to carefully consider the recommendations and funding levels as contained in the Independent Budget for VA which has been provided to the committee. This budget document represents the cumulative and cooperative efforts of four major VSOs (DAV, AMVETS, VFW, and PVA) and represents, in our view, realistic funding levels that would allow the Department to carry out its mandated mission of providing health-care services to disabled veterans.

MEDICAL AND PROSTHETIC RESEARCH

Mr. Chairman, the administration's FY 1991 medical and prosthetic research budget request is $198.5 million, $14.1 million below the FY 1990 funding level with a reduction of 421 FTEE.

We are pleased to witness an increase of $1.1 million in the rehabilitation research account.

The DAV has, and continues to be, fully supportive of the VA's combined research efforts. Not only has this activity greatly alleviated the pain and suffering of countless service-connected disabled veterans, it has also provided the means to help restore many of them to being productive, tax paying citizens. Moreover, the results of VA research activities have benefited society as a whole.

It is discouraging, therefore, to continue to witness appropriation requests that can only greatly impair the effectiveness of these activities. We believe the Independent Budget's recommended appropriation of $255 million for combined research activities is needed to restore a vitality to VA research activities.

CONSTRUCTION

The administration's FY 1991 construction request totals $694.5 million. Mr. Chairman, while we support full funding of the VA's request for construction purposes, we are nevertheless concerned that the requested amount will not meet the pressing needs of the health-care system.

As you know, greater numbers of elderly veterans are seeking nursing home care from the VA, yet, in this construction budget proposal, funding has been requested for minimal new nursing home care bed construction in the form of one, 120-bed Nursing Home Care Unit. Additionally, we are concerned that this construction budget request does not adequately recognize and address the replacement and modernization needs of the VA's many aging health-care facilities. In this regard, Mr. Chairman, we urge the committee to favorably consider the construction recommendations of the Independent Budget.

We have noted and support the VA's proposal to convert acute care hospital beds to nursing home care beds. However, in so doing, we would urge the administration to move swiftly in the conversion process and, when and where indicated, identify additional acute care beds that may realistically be converted to nursing home care. In doing so, we trust an appropriate balance will be maintained to meet the acute, intermediate and long-term health-care needs of our rapidly aging veteran population.

PROPOSED LEGISLATION

The administration's FY 1991 budget request proposes legislation that would provide:

—a 3.9 percent cost-of-living increase in the rates of disability compensation and Dependency and Indemnity Compensation (DIC) benefits, effective December 1, 1990;

—indexing compensation benefits to the annual change in the Consumer Price Index (CPI);

—placement of a limitation on the estates of incompetent veterans with no dependents;

—a revision in the criteria for the reduction of monthly non-service-connected pension benefit payments for veterans residing in VA nursing homes or domiciliaries;

—access to Internal Revenue Service (IRS) income information to verify means-based benefit programs;

—elimination of the Manufactured Home Loan Program;

—the extension of permission for manufactured home loan guaranty claims to be filed upon receipt of VA resale price;

—merger of the Direct Loan and Loan Guaranty Revolving Funds;

—inclusion of VA's losses in the determination of net value;

—a requirement of a downpayment of 4 percent to participate in the VA Home Loan Guaranty Program;

—an increase from 1.5 percent to 1.75 percent the VA Loan Guaranty Program funding fee;

—an increase from 10 percent to 30 percent the disability evaluation level for service-connected disabled veterans to be exempt from the VA Loan Guaranty Funding fee;

—authorization of a waiver of the direct loan's liability of $1.7 billion to the Treasury Department.

—an increase from $500 to $1000 the dollar limit for any fee for dental treatment before reexamination by a VA dentist or a second opinion by a private dentist is required;

—VA to furnish dental care to veterans with no direct entitlement to such care, but are active in a VA treatment program;

—limited outpatient dental treatment to veterans in a prebed care program prior to hospitalization;

—authority to provide outpatient dental care to World War I veterans;

—authority to furnish outpatient dental care to all former of prisoners-of-war on the same basis as medical benefits are provided;

—oral health-care services to veterans receiving home based hospital care;

—renovation costs for 10 child care centers in 1991 and a total of 50 by 1995;

—revision of the Title 38 nurse pay system;

—Saturday premium pay for nursing assistants;

—an increase in the amount of special pay for physicians and dentists;

—transfer of the billing and collection staff and related resources from the medical care appropriation to a third-party medical recovery appropriation;

—a requirement of co-payments by certain veterans receiving outpatient care; co-payments for filing prescriptions at a VA pharmacy; and a per diem payment for inpatient care and;

—authorization for recovery from third party health insurance companies for treatment of non-service-connected disabilities for insured service-connected veterans.

Mr. Chairman, DAV is pleased with the administration's proposed cost-of-living adjustments in the rates of disability compensation and DIC benefits—in recognition of the special consideration service-connected disabled veterans and their survivors should be given. Accordingly, the DAV supports the enactment of legislation that would provide disability compensation and DIC recipients with a cost-of-living adjustment in line with the rise in the Consumer Price Index effective December 1, 1990.

As strongly as we support this rate increase, we continue to adamantly oppose any effort to index compensation benefits to the annual change in the Consumer Price Index.

Mr. Chairman, in our view, the many and complex benefit programs administered by the VA deserve and, in fact, require, continuous oversight scrutiny by the Congress and, specifically, the Veterans Affairs Committees. Any attempt to index compensation benefits is, in our view, an attempt to diminish the oversight functions of the Congress. Such a result would not be in the best interest of the VA or, more importantly, the beneficiaries they are mandated to serve.

With respect to the proposal to place a limitation on the estates of incompetent veterans with no dependents, Mr. Chairman, we are concerned with any proposal that affects payment of compensation to service-connected disabled veterans. We have not seen such proposed legislation, nor have we had an opportunity to study this proposal in detail. Accordingly, we will withhold our views on this proposal to alter compensation payments to incompetent veterans.

With respect to the proposal to authorize accessing Internal Revenue Service records to verify the income of means-based benefit recipients, DAV generally has no objection to reasonable efforts to ensure that means-tested programs are not abused in accordance with the law. We are pleased to note this legislation does not apply to compensation recipients. Should such a proposal be forthcoming, the DAV would be adamantly opposed to any legislative proposal to utilize IRS income information to verify the income of compensation recipients.

Mr. Chairman, the proposal to revise the criteria for pension reductions for veterans residing in VA nursing homes and domiciliaries would extend from 3 months to 12 months the period of time prior to reduction, and would allow up to $10,000 of withholdings to be returned to veterans upon release from VA care.

In our view, this appears to be a well thought out, justifiable legislative proposal that would clearly meet the needs of veterans who rely on non-service-connected pension benefits to meet their basic financial needs. We certainly do not oppose the intent of this legislation, Mr. Chairman, and commend the efforts of the administration to liberalize this benefit program for this category of needy veterans.

Mr. Chairman, with respect to the Department of Veterans Affairs (VA's) loan guaranty program, we are opposed to the administration's proposal to require a downpayment from certain veterans to participate in the Home Loan Guaranty Program, as well as the administration's proposal to increase from 1.25 percent to 1.75 percent the funding fee for a guaranteed loan, and the administration's proposal to eliminate the funding fee exemptionfor service-connected disabled veterans rated 10 percent and 20 percent service-connected disabled.

Despite past problems, the VA Home Loan Guaranty Program is designed to give veterans and their families the opportunity to purchase a home following the return from providing honorable military service. In addition to being a moral obligation from a grateful Nation, it is a basic entitlement for veterans who deferred obtaining higher education and productive employment in our economy to serve their country.

We find it interesting, Mr. Chairman, that the administration has apparently been planning to increase from 1.25 percent to 1.75 percent the funding fee at the same time Congress adopted legislation establishing the Guaranty and Indemnity Fund during December 1989. It seems more than reasonable to give this restructured program an opportunity to succeed, given the fact that the Congressional Budget Office has stated the creation of the Guaranty and Indemnity Fund crafted by Congress would be self-supporting through the 1990's, and save $2 billion over 10 years.

Additionally, Mr. Chairman, DAV is adamantly opposed to the administration's legislative proposal to eliminate the funding fee exemption for service-connected disabled veterans rated 10 percent and 20 percent disabled.

As you know, Mr. Chairman, when a funding fee was initially established for VA guaranteed home loans, this committee—and Congress—very wisely and thoughtfully exempted compensably service-connected disabled veterans from this provision. The rationale then was that veterans who have incurred compensable service-connected disabilities while serving in our Armed Forces, personally having sacrificed more than others, should not be subjected to a funding fee to improve solvency of the Loan Guaranty Revolving Fund.

Mr. Chairman, with your indulgence, and for the benefit of administration "budget makers," the Schedule for Rating Disabilities, used by the VA to rate disabilities, requires the assignment of a 10 percent or 20 percent rating for the following combat incurred disabilities:

—traumatic amputation of the thumb, minor;
—traumatic amputation of index, middle, ring, or little finger;
—traumatic amputation of toes;
—some through and through gunshot wound injuries of the forearm, lower leg, back, or neck;
—tinnitus and/or hearing loss;
—facial scars;
—pleural cavity gunshot wound with bullet fragments retained in the lung.

Mr. Chairman, the rationale previously employed by Congress to exempt compensably service-connected disabled veterans from the funding fee is as valid now as it was in the past. We categorically and emphatically reject this administration proposal in its odious entirety.

Mr. Chairman, as we understand it, the administration's proposal to change the net value determination currently employed by VA to determine if they will obtain a foreclosed property or pay the guaranty, is based on the assumption that all properties acquired by the VA will be sold at a substantial financial loss. Many would argue that this assumption is faulty, especially in view of the fact that the economy continues to progress. Also, areas of the country where the housing market was particularly hard hit by the housing recession of the 1980's are starting to rebound.

Mr. Chairman, no matter what one's opinion may be regarding the housing market, the fact remains that Congress addressed the issue of "no-bids" in Public Law 101-237, which only recently became law. It would seem prudent that we give these new provisions of law—overwhelmingly supported by Congress—a chance to take effect. Therefore, Mr. Chairman, the DAV sees no reason to support further modification of this program at this time.

We are all aware, Mr. Chairman, of the severe problems the VA manufactured housing program has been plagued with over the past several years. Inventory padding schemes, high foreclosure rates and the rapid depreciation rate of mobile homes, just to name a few, have combined to cause severe financial losses in the VA loan guaranty program—not to mention the financial hardships placed upon our Nation's veterans and active duty personnel.

The administration's proposal to eliminate the VA manufactured housing loan program, at first blush, may seem to be the answer to the many problems in this beleaguered program. However, when one views the program as the veterans benefit program that it is, other less draconian solutions may come to mind.

For example, since more than one-half of the manufactured housing loans are issued to active duty personnel, Congress may wish to shift the financial burden to the Department of Defense (DOD) for the active duty mobile home foreclosures. After all, a significant number of active duty mobile home foreclosures are a result of transfer. Also, DOD may wish to take title to foreclosed mobile homes to help in the military base housing shortages.

Mr. Chairman, we believe that to eliminate a veterans benefit just because a program is experiencing problems, without looking for viable solutions, does not respond well to the commitment this Nation has made to its current and former uniformed defenders. Accordingly, the DAV must oppose the total elimination of the VA's manufactured housing loan guaranty program.

The administration proposal to establish the value of a mobile home at time of foreclosure seems, to us, to be a reasonable and prudent change to current practice of establishing the value at time of sale—which could occur several months after foreclosure. To us, it seems only reasonable that any loss (or gain) on resale should be absorbed by the holder of the foreclosed mobile home.

Legislation has also been proposed by the administration to consolidate the loan guaranty and direct loan revolving funds. The DAV has no objection to this proposed merger so long as the direct loan program for our Nation's severely disabled veterans is not negatively effected by this merger.

Mr. Chairman, it appears that the various dental provisions being proposed may tend to better serve veterans. However, we wish to defer specific discussion of such proposals until such time as we have had the opportunity to review specific legislative language in detail.

The DAV continues to be generally supportive of legislation which is intended to enhance the Department's ability to recruit and retain qualified health-care personnel. We will be anxious to review the VA's legislative proposals, as well as any others that may be for consideration, and work with the committee to ensure that salaries and benefits of VA health-care personnel are competitive. Only when this is accomplished will the Department be in a position to adequately recruit and retain qualified health-care professionals.

The DAV opposes any proposal that would require additional co-payments to be made by veterans in order to receive VA health-care services. In our view, such proposals have the underlying theme of structuring the veterans' health-care system to parallel that of the private sector.

A secondary purpose exists, in our view, to simply force a large number of veterans away from the VA, thus diminishing the base and patient mix of veterans able to utilize the system. The end result: a deliberate and purposeful attempt to dismantle the system to a point of ineffectiveness. Simply stated, we view this proposal as an attempt to require veterans to pay for the privilege of utilizing earned VA benefits and entitlements.

The DAV opposes such a proposal and would urge the committee to reject it.

Likewise, the DAV is adamantly opposed to any measure that would grant authority to the Department to recover the cost of health-care services provided to service-connected disabled veterans. Again, this proposal contains the obvious theme of radically restructuring the veterans' health-care system in an over-restrictive manner and sends a clear signal to service-connected disabled veterans that yet another earned benefit and entitlement is being stripped from them.

S. 2101

Introduced by yourself, Mr. Chairman, at the request of the administration, S. 2101 proposes to waive the waiting period requirement of Section 210(b)(2), title 38, United States Code, to permit the VA to transfer the loan guaranty division from Togus, ME, to the Manchester, NH VA regional office.

It is our understanding, Mr. Chairman, that VA intends to consolidate all loan guaranty operations in the New England area at the Manchester, NH VA regional office. This planned reorganization follows the recommendations of a task force of the various New England VA offices and loan guaranty service.

Mr. Chairman, DAV would be among the first to applaud VA management initiatives that improve program service to veterans in a cost effective manner. Having stated this, we wish to make it perfectly clear, Mr. Chairman, that the DAV opposes the consolidation or centralization of VA regional office claims processing services.

While we understand the task force recommending consolidation of New England loan guaranty operations included some VA loan guaranty personnel from the New England area, it does not appear that all interested parties—especially those in the loan guaranty division in Togus, ME—agree with this proposal. The following is a list of some of their concerns expressed to DAV personnel working at the VA Medical and Regional Office Center, Togus, ME:

—the lack of local control in each area affected by consolidating loan guaranty functions will cause delay resulting in losses and cost effectiveness;

—economies of scale may sacrifice service to veterans;

—a decrease in lender participation may result from consolidations;

—the accessibility of "hands on" VA representatives will be lost with a resulting decrease of loan guaranty usage by veterans in the affected areas;

—the welfare of dedicated VA employees is not taken into consideration in this consolidation;

—veterans' service division is not equipped to respond to veteran's inquires concerning loan guaranty benefits; and

—the servicing of delinquent loans may suffer.

Mr. Chairman, quite frankly, the DAV is concerned and dismayed that our input was not solicited by the VA on this proposed consolidation. We are also aware that this is not an isolated consolidation plan. In addition to the New England loan guaranty consolidation, the VA is considering merging certain regional office compensation and pension functions of Wilmington, DE; Togus, ME; White River Junction, VT; Fort Harrison, MT; Fargo, ND; and Sioux Falls, SD with the activities of larger regional offices in neighboring States.

Additionally, Mr. Chairman, as it pertains to the general subject matter of this bill, it has recently come to our attention that VA Central Office is considering consolidation of the Los Angeles and San Diego, CA, VA regional offices to a new site in the Bakersfield, CA area. We are deeply concerned, Mr. Chairman, that consolidation of regional office claims processing functions of this (or lesser) magnitude will adversely affect veteran claimants' accessibility to VA operations, and service delivery of benefits to our Nation's veterans.

Obviously, such consolidation measures would require veterans to travel greater distances to seek face-to-face benefits counseling, vocational rehabilitation counseling, and to attend personal hearings at distant VA regional offices.

We are equally dismayed that Secretary Derwinski's staff has not consulted veterans' service organizations or (apparently) Congress with respect to these plans.

As noted above, there exists considerably divergent views from the Togus, ME regional office professional staff and VSO's regarding consolidation of loan guaranty operations in New England, and compensation and pension adjudicative functions elsewhere.

Since some of those views persuasively suggest consolidation efforts of loan guaranty operations in New England may adversely affect veterans, we are unalterably opposed to S. 2101 at this time.

S. 2103

Mr. Chairman, S. 2103 proposes to waive the reporting and waiting period requirements of Section 210(b)(2), title 38, United States Code, to implement an administrative reorganization reducing from seven to four the number of regional field offices of VHS&RA.

The Secretary's stated rationale in desiring to move forward with such a reorganization is to overcome a perceived lack of administrative uniformity of the medical care system; to eliminate regional variation relating to access of care; to streamline VHS&RA by removing an unnecessary management layer; and to ultimately improve services to veterans.

More to the point, the benefits hoped to be achieved include:

—greater balance between the operational uniformity of the system and management flexibility for individual facilities;

—more efficient use of resources and improved communications by removing duplicative functions and administrative layers;

—redeployment of resources, including personnel to support direct patient care;

—increased accountability for implementation of centralized policy; and

—greater uniformity among regions of access to health-care services.

Mr. Chairman, the DAV is generally supportive of plans or actions that will truly serve to improve the delivery of services to veterans while, at the same time are capable of streamlining VA management and, as' this proposal proffers, effectuate cost-savings that will be reprogrammed to directly benefit veterans, in this case by augmenting staffing for direct patient care.

We are, however, concerned with certain seemingly unresolved issues relating to the planned reorganization.

As you are well aware, Mr. Chairman, concurrent with the planned change of regions from seven to four is the related issue—not requiring legislative action—of eliminating the existing 27 medical districts.

Our concern relates to certain vital functions currently performed by the medical districts and the ability to successfully integrate them into the regions that is now in question.

Mr. Chairman, we are not yet completely satisfied that functions such as planning, fire and patient safety and the various quality assurance activities are readily transferable to the new regional configuration being proposed.

In our view, these issues must be fully addressed and an acceptable plan be put in place for the integration of these functions prior to the reorganization plan being implemented.

Therefore, we will not necessarily oppose the enactment of S. 2103.

U.S. COURT OF VETERANS APPEALS

Mr. Chairman, I take this opportunity to again thank you and the members of this committee for your outstanding contribution to our Nation's veterans in the form of passage of Public Law 100-537, establishing the U.S. Court of Veterans Appeals (COVA).

For Fiscal Year 1991, the administration's budget request for $8,960,000 will support an average FTEE level of 99, as well as normal operating expenses of the

Court. This represents an increase of $5,670,000 and 54 FTEE over the FY 1990 appropriated level.

As you are aware, Mr. Chairman, under Chief Judge Frank Nebeker, the new Court has only recently begun full-time operation at a temporary location in Washington, DC. Since the Court has not yet completed a fiscal year of operation, it is difficult to assess their budgetary needs.

Nevertheless, according to the administration's budget submission, the caseload of the Court during their first full year of operation is expected to exceed 5,000 cases. This equates to over 700 cases per sitting judge, and as the administration's budget submission properly points out, this is an extraordinary case-to-judge ratio. The Board of Veterans Appeals has indicated that over 11,000 cases are currently eligible for appeal to the Court.

Mr. Chairman, it is likely that the caseload of the Court will increase as publicity about its operations and its decisions become more widely known. Considering the number of potential cases currently eligible for review by the Court, we respectfully submit that Congress should provide full budgetary support for their appellate requirements.

I will parenthetically note, Mr. Chairman, that the Disabled American Veterans has organized and staffed an office to represent veterans before the new Court. As future COVA operations and developments occur, and their resource requirements (or shortfalls) come more apparent, we will be pleased to provide this committee any information that would enhance the Court's operational effectiveness, with respect to those disabled veterans we intend to represent before the Court.

Mr. Chairman, we would like to comment on the Department of Labor's FY 1991 budget request for the Veterans' Employment and Training Service (VETS). We have had an opportunity to review the administration's budget request for VETS, and in some respects we find it adequate, and others, totally inadequate.

Section 2003A of title 38, United States Code, establishes a funding formula for the assignment of Disabled Veterans Outreach Program (DVOP) specialists. According to that formula, 1,883 positions are authorized, at a total cost of $79,076,000. However, the administration's FY 1991 request is $74,473,000, which is sufficient to fund only 1,730 positions. The administration's FY 1991 budget request for DVOP is $4.6 million short for a reduction of 153 positions from those authorized by law.

Section 2004(a)(2)(A) of title 38, United States Code, establishes a formula for the funding of Local Veterans' Employment Representatives (LVER). Based on that formula, 1,600 LVER positions are authorized at a cost of $72,851,000. The administration's FY 1991 request falls short, as they are requesting only $68,608,000, which is sufficient to fund only 1,465 positions. This represents a shortfall of $4.2 million and 135 LVER positions.

In reviewing the administration's FY 1991 request for the VETS budget, it should be pointed out that the administration's request is actually $84,000 over Fiscal Year 1990's operating budget. By contrast, Fiscal Year 1990's operating budget is $2,835,000 more than Fiscal Year 1989's operating budget. This is strictly for DVOP.

For FY 1991 the LVER program would be increased by $76,000. But again, by comparison, FY 1990's budget was $3,619,000 more than FY 1989's budget.

It is very easy to see that while the administration is requesting an increase in the dollar amount, there will be a reduction in personnel.

The request for VETS Federal staff including the national office, Directors and Assistant Directors, is 288 positions. This is the same as Fiscal Year 1990. (This breaks down to 251 field staff and 37 in the national office.)

We are also concerned about the budget request for the National Veterans' Training Institute (NVTI). As you may be aware, the DAV argued for almost 10 years that a national standardized training system was needed for DVOPs and LVERs. Finally in 1986, the Department of Labor established what is now known as the National Veterans' Training Institute (NVTI). On May 20, 1988 the President signed Public Law 100-323 in which Congress wisely emplaced NVTI as a permanent program. NVTI has since been providing the type of training we believe is essential for DVOPs and LVERs to adequately carry out their duties.

In Fiscal Year 1989, NVTI operated on a budget of $2,211,000. Fiscal Year 1990 saw a decrease of $66,000 to $2,145,000 and the FY 1991 request virtually puts NVTI out of business. The administration's budget request is only $829,000, a decrease of $1,316,000. The overall decrease from FY 1989 is almost $1.5 million. What this also means is that in FY 1991 only 500 participants will be trained through NVTI. In Fiscal Year 1989, 2,867 people participated. Other highlights of the requested budget include $225,000 to partially fund the Transition Assistance Program (TAP). This program began in Fiscal Year 1989 with the military service branches and they plan to expand it up to "20 additional DOD sites." There are 42 two components of

TAP: (1) the Disabled Transition Assistance Program (DTAP) and, (2) the Veterans Transition Assistance Program (VTAP). TAP provides active duty military, who are within 180 days of separation, employment and other information regarding career prospects following their discharge. We question whether this amount is sufficient.

For FY 1991, the administration is requesting $8,863,000 for title IV-C veterans' programs under the Job Training Partnership Act (JTPA). This is a decrease of $482,000 from the Fiscal Year 1990 appropriation.

In addition, the FY 1991 budget proposes an increase of $280,000 to provide employment assistance and other supportive services to homeless veterans.

Mr. Chairman, the DAV worked long and hard with the Veterans' Affairs Committees in both houses to assure an acceptable level of employment services to our Nation's veterans, especially disabled veterans. We don't believe a reduction of 153 DVOPS and 135 LVERs will be adequate to deliver those services.

We are satisfied with the funding levels for the Federal staff, both at the National and State level.

This concludes my testimony, Mr. Chairman. I would be pleased to respond to any questions from you or members of the committee.

PREPARED STATEMENT OF JOHN C. BOLLINGER, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and members of the committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the administration's proposed fiscal year 1991 budget for the Department of Veterans Affairs. We would also like to give you an overview of the Fiscal Year 1991 Independent Budget for Veterans Affairs.

The Independent Budget this year, again, represents the combined efforts of PVA, AMVETS, Disabled American Veterans and Veterans of Foreign Wars with our views as to the status of the Department's programs for veterans and the recommended funding levels required in FY 1991 to properly meet the needs of all eligible veterans.

We have entitled this year's Independent Budget, "The Price of Peace—The Nation's Obligation: Correcting Budget Priorities For Veterans." So often, in referring to our Nation's obligation to care for those who have served in our Armed Forces, we have all referred to this debt as a continuing cost of war and the defense of this Nation. The title of the Independent Budget this year is a logical extension of that concept.

The ultimate objective of war and conflict is peace. The men and women who have served and sacrificed—the men and women who have stood guard on the front lines of freedom and democracy have indeed paid the full measure. They are responsible for securing the reductions of tensions and the spirit of peace and cooperation that is breaking out all over the world today.

What used to be the continuing cost of war is now the continuing price of the peace we now look forward to. The commitment we hold for those who have served and sacrificed in defense of this Nation should not lessen now that the walls are coming down and the barbed wire is being rolled up and thrown away. The Nation's obligation and the Nation's gratitude for this service should actually be greater now that the ultimate victory of peace is within our grasp. This is the true peace dividend—a dividend our Nation's veterans should rightfully share.

FISCAL YEAR 1990 FUNDING OUTLOOK

Mr. Chairman, a year ago we came before this committee to tell you, that from our perspective, the VA health care system was in a State of crisis—a viewpoint that we know you and this committee shared. Rising demand and cost of health care services, coupled with years of inadequate budgets had finally brought the VA system to the breaking point. Chronic funding shortfalls had forced the rationing of health care to eligible veterans, massive shortages of equipment supplies and staff, and a dangerous erosion in the morale of VA employees, all of which had seriously compromised the system's ability to provide quality health care.

Coupled to these problems is a seriously flawed resource allocation system that encourages competition for budget dollars between station and station based on increased workload. This continues to happen when the medical care dollars are not available to provide that care. The result forces a medical center director to cannibalize needed funding for equipment, supplies, prosthetics and maintenance in order to keep these workload numbers up at the expense of both quality and quantity of care.

We are back again at this table to tell you, that despite our best efforts and yours, this serious situation has not improved. Funding for VA health care, despite the increases provided in the FY 1990 appropriation, is still far behind the curve needed to provide for a level of services comparable to the FY 1988 level. The Independent Budget estimates that, as the funding shortfall continues to roll over and compound from year to year, our FY 1990 estimates show the current funding level to be $750 million short of meeting current services. This deficit will continue the serious erosion in the quality and quantity of health care services unless steps are taken immediately to reverse this trend.

The first week of November, 1989, Independent Budget staff conducted a telephone survey of 24 representative VA medical centers. Survey questions were designed to elicit information on any continuing impact of a residual FY 1989 funding shortfall and the system's ability to handle the projected continuing shortfall in FY 1990. Every hospital surveyed reported that deficits were still being absorbed by workload cutbacks and use of funds intended for equipment purchase, building maintenance and repair, personnel salaries and contract health care services, such as community nursing homes. In the latter case, facilities cut utilization between 10 percent and 50 percent.

Most hospitals reported:

—A residual deficit, ranging from $1 to $4 million per hospital, after receiving their share of the belated FY 1989 supplemental appropriation.

—Multimillion dollar backlogs, ranging in value from $1 to $17 million in needed but unpurchased equipment.

—Between 20 and 50 nurse vacancies per hospital—particularly in intensive care.

—Waiting times of more than 3 months for certain specialty clinics (some clinics had a 6 month backlog).

—Projected funding shortfalls in FY 1990, ranging from $40,000 to $50,000 for prosthetic services and equipment (from wheelchairs to leg braces)—even though FY 1989 nonrecurring supplemental dollars were invested in prosthetics.

—In every hospital surveyed, poor employee morale.

We note with concern that the administration has stated there will be no supplemental appropriation request sent to the Congress for the Department this year. We know that you too, Mr. Chairman, have identified a shortfall for the current year of approximately $250 million in basic supplemental funding needed this year. This figure does not even include additional funds to help reduce the serious backlog in the purchase of medical equipment. We estimate this shortfall to be approximately $500 million at the present time. We greatly appreciate your efforts, and the support of 40 other Members of the Senate, in writing to President Bush on December 22, 1989, urging supplemental request this year.

ADMINISTRATION'S FY 1991 BUDGET PROPOSAL

The administration's proposed fiscal year 1991 budget requests $30.9 billion for the Department of Veterans Affairs. The budget proposal represents an increase of $961 million over current FY 1990 spending. If the request is approved by Congress, veterans' medical care would receive approximately $12.2 billion—a $901 million increase over this year's level. On the downside, the recommendation seriously erodes funding for VA research, makes deep cuts in medical administration resources, and dangerously reduces staffing for the Veterans Benefits Administration at a time of soaring backlogs in claims processing and adjudication.

The President has recognized, that indeed, a funding problem needs to be rectified by recommending these increases in medical care. We are grateful for Secretary Derwinski's hard work throughout the budget preparation process in negotiating with the Office of Management and Budget, and all the way to the Oval Office itself, in arriving at these budget figures. However, while the increases represent a proposed improvement in the current funding crisis, in our opinion, the budget still falls far short of compensating for past shortfalls, maintaining quality care, and meeting anticipated demands for the coming year.

The administration's request represents an approximate 8 percent increase in medical care over this year. At the same time, medical inflation rates have been running 8 to 10 percent for the past several years. A chart we are including as "Attachment A"—Federal Health Budget—Average Annual Percent Change FY 1985-1989," clearly shows that in comparison with all other Federal health entities, veterans' health services have not received their fair share of Federal health dollars to keep up with inflation. For instance, since 1985 Medicare has received a 44 percent increase; Medicaid received a 58 percent increase. Veterans' health care has received only an 18 percent increase. VA research has received 7 percent less during this time. Discounting for inflation entirely, VA funding during this period has actually been decremental. The point we are making is that the proposed 8 percent increase for medical care in FY 1991 is welcome, but it does not solve the problem that we face.

The Independent Budget recommends a medical care budget level of $13 billion just to meet current services requirements. Our total recommendation for medical care is $13.4 billion.

In deriving this figure we have factored the total amount of the projected increase in cost of medical care services between now and 1995. The costs are incurred primarily in estimating increased resources needed to take care of the aging veteran population and the rising cost of medical care itself. The approximate $400 million over 1991 current services level is a one-fifth increment of that total amount placed in the FY 1991 budget to help prepare now for the increasing costs that will be incurred gradually over the next 5 years. There is no need to get cut short again 5 years from now when we can start preparing for those increasing commitments now.

Calculating Independent Budget current services and projected funding needs for FY 1991, the administration's proposal is still approximately $700 million below the current services level. Judging our total recommendation, the administration request is nearly $1 billion below the level needed to bring medical services to a level of projected demand.

The differences, between the administration's figures and our own, are derived from how those figures are tallied. The Office of Management and Budget has abandoned accounting for "current services" as the approach to budgeting from 1 year to the next. The increases called for in the President's submission are based on merely adding to a FY 1990 appropriation which is already, by the committee's estimate, $250 million below needed levels ($750 million by Independent Budget estimates). The original 1990 request was based on the funding levels provided in FY 1989 and so on. The budget "snapshot" is retrieved each year without any regard to cumulative deficits in available services that have accrued from an eroded resource base from 1 year to the next.

We know that if this year's funding level is insufficient, 1989 was a complete disaster. The appropriation was nearly $640 million short of anticipated needs, creating absolute chaos in the system. The hard-fought supplemental that year, $320 million, arrived too late in the year to provide major relief to most medical care programs in the direct service areas, except to help alleviate needed equipment purchases. Plus, the supplemental was not annualized and did not carry over into the budget base for FY 1990.

Fortunately, the Congress, through the help of this committee, has gone a long way in greatly improving overall funding levels. The Congress appropriated $858 million over the administration's request in FY 1990 alone. Without this understanding and assistance, we are certain VA medical facilities would be closing their doors. However, while higher than the administration requests, the appropriated amounts have not been sufficient even to stabilize the level of grossly inadequate delivery of medical care and benefit delivery that continues to build.

The Office of Management and Budget continues to plan with significant shortfalls carried over from 1 year to the next. There is simply no historical perspective as to where the specific shortfalls came from and how they compound the Department's ongoing funding problems. This problem has grown at a time of increasing veteran health care demand and skyrocketing medical costs, eroding VA budgets from 1 year to the next, year after year. The Independent Budget, on the other hand, for the past 4 years, has based its budget projections on a service delivery model. We estimate the projected dollar need, not just a lump sum dollar amount as OMB does, but on a carefully projected analysis of what services need to be provided—how many veterans will need those services, and what those services will cost. Since the first Independent Budget was released, we have carefully tracked the rising cost of those services from 1 year to the next, comparing that current services figure with the actual appropriations provided in each individual year.

Unlike OMB's projections, and in certain instances, final appropriations figures that are based on what the veterans' budget will "get" within the competition over the entire Federal budget pie, the Independent Budget's figures are based on what the Department actually "needs" to meet service levels, demand and quality of care in any given year.

In the case of the FY 1991 proposal, we returned to FY 1988 appropriation, using those figures as our baseline. The FY 1989 figures were such a disaster for the Department and service levels dropped so low in inpatient, outpatient and nursing home care as a result, (see attachments B, C, and D) that no reasonable comparison could be made that could provide any continuity for an ongoing current services analysis based on true veteran demand.

On this basis, we believe our recommendations for FY 1991 are accurate appraisals of what the Department will actually need next year to make up accumulated lost ground and maintain the quality and quantity of health care and benefit delivery. A summary of the Independent Budget recommendations are attached to this testimony.

We believe that the Independent Budget is beginning to have significant influence even in the administration's budget formulation. For the first time in many years the administration has dropped its recommended 1 percent cut for "productivity improvements." The budget calls for up front funding of the annual pay raise, rather than having partial funding provided later in the year with the Department absorbing the balance out of existing funds. The budget provides a significant funding increase to help cover the increasing cost of caring for AIDS patients. There are funds earmarked for the unit dose system and the commitment to complete conversion to this drug distribution program within VA medical centers by 1995.

HEALTH CARE STAFFING

More than 60 percent of direct health care costs are related to personnel expenditures. The administration's budget calls for 2,837 additional FTEE in FY 1991. Included in this figure are 800 additional nursing position. There is no question these new positions will be of great benefit to the VA health care. However, on scrutiny, the budget proposal reveals that 2,098, the vast majority of those FTEE, are requested to staff newly activated facilities, not to augment the existing system where thousands of beds have been closed do to lack of staff, particularly nursing staff. Only half of the remaining 739 additional FTEE are to be allocated to the existing hospital system. The remainder are to be sent to fill needed nursing home positions.

PVA, and the Independent Budget have long criticized budget proposals with insufficient funding to fully staff and equip newly activated facilities. It is irresponsible to provide the funds to construct needed new facilities, such as Spinal Cord Injury Centers, and then leave them half empty for months because of a lack of funds for equipment and staff. We applaud the major use of these new proposed funds to correct these deficiencies. However, the majority of FTEE funding going to new facilities does little to correct major staffing deficiencies throughout the existing system. The increases for new activations should be added to the congressionally mandated FTEE floors, not included as part of the total staffing requirements for the existing system as it was before these facilities were built.

Again, the administration's request, while significant in attempting to make up for prior shortfalls and obligations of new construction and increasing workload, does not go far enough in correcting other existing gross deficiencies to help meet present and projected demand. Throughout the system the staffing proposal is helpful, but it does not go the whole way to reach parity with ongoing demands.

HEALTH CARE ENTITLEMENT

The Independent Budget believes that continuing under funding is eroding the ability of the system to provide entitled needy veterans access to appropriate health care. At the same time, this problem is compounded by ambiguities in health care entitlement allowing medical center administrators the opportunity to ration care accordingly. As a result, veterans in need of medical services simply aren't receiving the medical care they need. This problem arises primarily in the provision of outpatient care and nursing home care for veterans with category A entitlement.

The Independent Budget supports legislation that would provide "category A" veterans with entitlement to the full array of VA health care services—inpatient hospital, outpatient and nursing home care. We strongly believe that making a clear definition of health care entitlement will ensure that those veterans who require treatment receive the medical services they need in the most cost-effective manner.

We also believe that only with clear entitlement for care can the Department and the Congress properly define the universe of eligible veterans to be able to shape and fund the Department of Veterans Affairs in the future. The cost in 1995 of such a legislative proposal, particularly in the area of outpatient services, we believe, can be largely offset by the avoidance of even higher costs associated with short term and extended inpatient services for which "category A" veterans currently have entitlement. With regard to nursing home eligibility based on current projected utilization rates, we estimate that nursing home costs would be approximately the same under old and new entitlement rules for 1995.

MEDICAL AND PROSTHETICS RESEARCH

The administration's FY 1991 proposed budget for medical and prosthetics research will decrease both funding and FTEE for this important program. Reduced by $13 million below the FY 1990 appropriated level, the program will be unable to start many new research projects as well as force cutbacks in commitments to ongoing projects.

The budget authority requested for FY 1991 is $198,537,000. This level of funding, approximately $55 million less than that recommended by the Independent Budget, will further erode a program beset with inconsistent funding and disruptive personnel fluctuations.

Although we are pleased that spinal cord injury research has been given a high priority in this program, the truth of the matter is that every aspect of research will be adversely affected if the President's proposed budget is enacted.

Last September, the House committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, held a very memorable hearing on Rehabilitation Research. Those in attendance witnessed some incredible displays of what VA research dollars can do. PVA strongly urges Congress to ensure that VA will be able to continue to provide our Nation's disabled veterans with the best medical and prosthetics research available.

DVA CONSTRUCTION

Once again, the construction needs of DVA for maintenance, repair, and replacement of aging medical centers represent one of the most visible indicators of the desperate condition VA facilities are in today. PVA strongly endorses the funding levels recommended in the Independent Budget for Fiscal Year 1991.

The administration has requested a total of $694,467,000 in major and minor construction for FY 1991. Given the 86 year replacement cycle on which DVA facilities are operating, this funding level for FY 1991 will be far short of that needed to address the current nationwide requirements for construction and maintenance shortfalls. Changing technologies and demographics will further require modern state-of-the-art facilities. The Independent Budget recommendation of $970,750,000 for this account will be necessary to meet these current and future challenges.

The continued erosion in VA medical facilities severely restricts the quantity of health care available and severely endangers the quality of medical services provided to the veteran community. The problems causing this erosion are basically dollar driven and dollar restricted without regard to any proper long-term planning process.

There continues to be no sound, effective, or utilitarian process for proper facility development and improvement. PVA continues to believe the VA Facility Development Planning process is severely flawed. Accurate projections of national needs are nonexistent. Millions of dollars have been spent to design buildings never built or to redesign facilities based on errant utilization data or ever-tightening budget squeezes.

Obviously for the members of PVA, the excellence of VA Spinal Cord Injury Centers is extremely important because expertise in this area has not been widely available. The Department of Veterans Affairs has played an important role in the research and treatment of spinal cord injury and disease. SCI specialties embrace unique areas of a multidisciplinary approach to treatment involving neurology, urology, orthopedics, internal medicine, plastic surgery, mental health science, rehabilitation medicine, physical therapy, prosthetics and orthotics to name but a few.

Due to these many specialities, the average VA hospital ward is totally unsuited to provide adequate care for spinal cord injured patients. SCI facilities must, therefore, be carefully crafted and designed to pay careful attention to the specific and unique needs of these patients and the staff that cares for them.

DALLAS AND TAMPA SCI CONSTRUCTION PROJECTS

For the members of PVA, the planning and delays associated with the Dallas and Tampa SCI construction projects represent perhaps one of the most frustrating actions taken by VA on the provision of health care for spinal cord injured veterans.

DALLAS

The initial request for the Dallas, TE construction project was made back in 1972. The purpose of the project was to expand surgical and medical units, relieve severe space deficiencies, and upgrade a 1940's designed hospital into a truly state-of-the-art medical center. The facility has been sited by VA as one of the most active in the treatment of SCI patients.

In FY 1988, design funds for the $128 million project were authorized in the amount of $14.3 million. The FY 1989 appropriation contained $13 million for design funds for a major clinical addition, improvements, and an SCI center with 30 acute care beds and 30 long-term care beds. The preliminary designs were completed by VA in 1987 at a cost of $2 million.

As you well know, at the direction of OMB, the DVA has decided that workload projections for the facility, which were made only 2 years ago, are not accurate. The entire design must be scrapped and completely redrawn based on new projections which indicate an enormous increase in workload. Not only will the re-design be extremely expensive, but the project will again be delayed for several years. In the meantime, the $13 million appropriated in FY 1989 by Congress will sit in escrow and, most important, spinal cord injured veterans in the area, without access to an SCI center, will continue to go without specialized treatment in a modern treatment unit.

TAMPA

Like the Dallas project, the Tampa, FL construction project dates back to the early 1970's when a 41 bed SCI unit was activated at the Tampa VAMC. Over the next twelve years, projects to expand Tampa's SCI capabilities were held hostage to other agency-wide construction priorities.

As you know, a Master Plan was developed in 1985 for SCI construction in Florida and included a 30 bed SCI unit at the Gainesville VA Medical Center and a 80 bed unit in Tampa. After several years of inactivity on the projects, VA decided in 1988 to scrap the Gainesville project and build a 100 bed unit at Tampa. The House and Senate Committees on Veterans Affairs subsequently authorized expansion of the Tampa SCI unit to 100 beds for FY 1990. The House Appropriations Committee included $2.3 million in design funds for the $23 million free standing 100 bed unit. The Senate Appropriations Subcommittee on VA, HUD, and Independent Agencies has also expressed support for the project.

A reasonable person should be optimistic at this point that a new SCI facility will soon be available for spinal cord injured veterans in Florida. Unfortunately, VA has returned to their original plan from the mid-seventies to incorporate the funding and design for the 100 bed unit at Tampa with a major clinical addition. Yet another Facility Development Plan (master plan) is being developed. Estimated completion date for the project—1998 at the earliest!

Mr. Chairman, needless to say, we are becoming a bit gun-shy with VA projections and promises. Although 1998 is unacceptable to us, nothing has happened over the past 5 years to give us any reason to believe this facility will be available by the turn of the century. How much longer will severely disabled veterans truly be asked to wait for specialized SCI care? The history of this project and the funds wasted on plan after plan should be an embarrassment to the Department of Veterans Affairs which, for so long, has been on the cutting edge of SCI treatment and research.

Representatives of PVA recently met with VA's new Assistant Secretary for Acquisition and Facilities. We were impressed with what we believe is a sincere desire to confront the problems facing VA construction and find workable solutions. In regard to the Tampa project, we strongly recommend the following:

—VA should re-configure the FDP which is currently being developed so that the SCI unit is identified as a free standing structure.

—As soon as the SCI has been sited on the selected FDP, conceptual design should begin for the SCI project.

—Because design funding should already be provided, working drawings should be complete within two years so construction can begin in late 1991.

—As we have discussed in detail with VA, an interim solution (using minor construction funds) to the major space deficiencies should be implemented as soon as possible.

LONG TERM CARE—INCREASING NURSING HOME CENSUS

The Independent Budget makes specific recommendations for major expansions of noninstitutional extended care programs, such as hospital based home care programs, to help meet the increasing needs of the aging veteran population. The Department is far behind the curve, as well, in providing additional funding to increase geriatric treatment programs at all levels. However, of equal importance is the need to increase the Department's institutional long-term care capability to serve the growing number of veterans who have such severe functional limitations that they cannot be cared for in a noninstitutional setting. These services should include both an increase in specialized long-term care services, in such areas as spinal cord injury, as well as augmenting the number of beds in intermediate and skilled nursing home beds.

Our targets for nursing home care are based on a new analysis, grounded in the 1985 National Nursing Home Survey. The 1985 survey shows that nursing home use rates for each age group are no longer increasing, contrary to the pattern found in earlier survey. (The most recent survey covered 1977.) Our planning, calling for $110 million in FY 1991, therefore assumes a constant use rate for each veteran age group, and increases in the number of veterans in nursing homes resulting only from aging of the veteran population. For this reason again, we believe that a clear entitlement to long-term care for all "category A" eligible veterans, as recommended earlier, will not overly strain existing demand and present and projected long-term care funding levels.

Included in this proposal are recommendations for increasing funding for State veterans homes, community nursing home care and additional nursing beds constructed or converted from existing closed beds.

In the near term, the VA nursing home program must incorporate beds added by new nursing homes—now—in the construction "pipeline," and also grow through conversion of approximately 500 to 1,000 VA hospital beds a year. The administration's FY 1990 budget called for the conversion of only 149 beds. We believe that conversions can be achieved and the medical administrators will encourage those conversions if appropriated FTEE are allocated for that purpose. For the long-term, we propose that 500 VA nursing home beds be added to the system annually through the completion of four new 120 bed nursing homes each year in addition to conversions.

THIRD PARTY RECOVERIES AND PROPRIETARY RECEIPTS

The administration's proposed budget recommends several strategies to increase receipts from either veterans or third party payers for the cost of providing health care to eligible veterans. We would advise the committee to proceed with extreme caution before approving any of these proposals.

The budget would establish a collection effort to increase existing third party medical recoveries utilizing additional VA staff to facilitate this collection effort. Part of the additional receipts collected would be utilized to offset the cost of collection. We have stated in the past our concern over the return to the Department of any receipts from third party collections. Despite "agreements" or "understandings" with OMB to the contrary, we remain concerned that the Office of Management and Budget will use those collections utilized by the Department as budget offsets decreasing funding for needed program costs in future budgets.

The budget would also expand existing law under the means test to require copayments for inpatient, outpatient and prescription drugs for both category B and C eligible veterans. The same provision would also require collections from third party payers for the cost of care for both category B and C non-service-connected veterans as well. PVA would oppose enactment of the legislation and recommends the committee not tamper with existing means test eligibility in this fashion.

The budget also calls for the legislative authority to collect from third-parties and certain service-connected veterans payments for the cost of care for the treatment of their non-service-connected disabilities. As we have in previous years, we again oppose this proposal. Veterans with service-connected disabilities have, and should maintain, the highest degree of priority within the VA system. Requiring payment for the cost of medical treatment provided under existing law would be a serious breach of that commitment. In addition, mandating third party reimbursement for the cost of care would require the Department to establish additional costly collection support systems. The provision would also, for the first time, require that the general population, including veterans, pay twice for the cost of veterans' health care: once through general taxes and revenues; and second, through increased health care premiums imposed across-the-board to cover the additional cost to them of the third party payments.

PROSTHETICS FUNDING

The Congress appropriated additional funds for FY 1990 to help alleviate the serious backlog in the provision of prosthetic and orthotic equipment for veterans. The additional funds were definitely welcome at a time when veterans have, according to our surveys, had to postpone even leaving the hospital for weeks if not months because wheelchairs were not available to give the veteran independence and mobility at home. However, merely providing additional dollars does not necessarily solve the problem or ensure that dollars allocated for prosthetic equipment are actually used effectively for that purpose by VA medical centers. We greatly appreciate your efforts, Mr. Chairman, in providing a careful ongoing review of VA prosthetics services.

However, as we have stated in the past, funding for prosthetics, running the gamut from wheelchairs, leg braces to every day medical equipment and supplies, is lumped into the general medical account allocation for each medical center. As unspecified funds, these dollars, already in short supply, have been used at the station level as available resources to "borrow" to cover shortfalls in other medical center accounts. This continues to be the case when hospitals do not have sufficient resources to maintain service delivery levels and must cannibalize resources for equipment and supplies in order to maintain patient care numbers to compete under the flawed current resource allocation method.

PVA knows that this committee is continuing to monitor problems associated with the provision of prosthetics. At the same time, as we and the Independent Budget have recommended in the past, we believe the only solution is to require the Department to account for funding of prosthetic equipment as a specific line item in the general medical care account.

VETERANS BENEFITS ADMINISTRATION GENERAL OPERATING EXPENSES AND BENEFITS PROGRAMS

The FY 1991 Independent Budget recommends staffing levels and appropriations within each service of the Veterans Benefits Administration (VBA). PVA believes these recommendations are a reasonable and realistic assessment of the current status of the General Operating Expenses (GOE) account and programmatic components of VBA. It is not our purpose, therefore, to reiterate all of the concerns and recommendations expressed in the Independent Budget. Rather, we will highlight the areas we believe are most deserving of your attention and comment on the probable effects of the administration's budget.

At the outset, we must State that the focus on health care issues has fulfilled our prophecy that the Veterans Benefits Administration, from a budget standpoint, has taken a back seat in the overall budgetary scheme for DVA. If the Veterans Health Services and Research Administration (VHS&RA) can be called a relative winner in this year's budget proposal, it certainly appears to have produced more than one loser in VBA.

One of the most troublesome aspects of the President's proposed budget for Fiscal Year 1991 is the funding request for the General Operating Expenses (GOE) account for the Veterans Benefits Administration (VBA). As the Independent Budget has documented, several years of inadequate budgets and appropriations have exacerbated the unacceptable level of FTEE and funding necessary to accomplish the objectives of VBA. To compound this issue, the devastating effects of sequestration have taken an extraordinary toll on VBA.

The Department's contention that the present level of employment in 1990, along with the employment requested in 1991, will allow VBA to improve the quality and timeliness of claims processed, just simply cannot be supported by any objective documentation and realistic assessment of the present situation in VBA. In addition, if VBA is able to improve loan servicing on delinquent GI and portfolio loans, it certainly will not be attributable to a reduction of 266 FTEE from the total current appropriated level of 12,600 FTEE for VBA. Any gains in one VBA service will be at the accelerated expense of other VBA services, none of which can afford further reductions in FTEE.

The President has proposed a 1991 funding request of $605.3 million and 12,334 FTEE for Fiscal Year 1991 for VBA. While this reduction from the current appropriated level of 12,600 is bad enough, when viewed against several other figures, the truly ominous significance of the budget proposal for VBA is readily exposed.

In 1987, the Veterans Benefits Administration employed 13,126 FTEE's. As evidenced by huge backlogs in pending claims and ever-increasing abandoned phone calls to counselors, however, service to veterans and their families was deteriorating rapidly. After carefully analyzing each service within VBA, we recommended a total of 13,343 FTEE's for FY 1989. Although Congress mandated no fewer than 12,898 FTEE's for that year (590 more than the administration requested), the mandated figure was never implemented. Instead, a subsequent supplemental appropriation brought total FTEE down to 12,700, and, in response to the administration's FY 1990 budget proposal, a further "compromised" settlement resulted in the 12,600 FTEE which VBA now "enjoys."

In other words, although the Congress has added FTEE's each year to the administration's proposals for VBA, the net result has been negative. For every step the Congress has taken forward, the administration has already taken two backward. The result can clearly be seen by reviewing the various services within VBA.

ADP Systems Management

As DVA's budget is thoroughly analyzed over the next several weeks, the Department will undoubtedly attribute all reductions in VBA's FTEE to savings generated from the modernization program. In fact, we are indeed encouraged by the increased investment in ADP funding for FY 1991. Although FTEE will remain stable at 437, the additional $13 million invested in VBA's twelve- point modernization plan will provide desperately needed funds to support that comprehensive project.

Included in the overall ADP effort, the Model Station Project and the Automated Medical Information Exchange (AMIE) are excellent examples of areas that need priority attention, continued funding, and national implementation. Neglected for too long, the basic ability for VBA and VHS&RA to exchange data has been one of the most glaring deficiencies in VA's ADP systems.

Unfortunately, VBA's ability to implement a sophisticated ADP system has not reached the point where a reduction of 266 FTEE can be justified in the name of modernization. There are too many short-range initiatives yet to be implemented for VBA to reduce employees and concurrently improve service to veterans. As the Independent Budget states, the state-of-affairs in VBA is currently so critical that only through an immediate increase in FTEE and improved ADP will the Veterans Benefits Administration be able to stop the plummeting decline in the quality of services available to veterans.

Compensation, Pension, and Education (CP&E)

An analysis of the backlog of unworked compensation, pension, and education cases is, perhaps, the most significant barometer of the deplorable situation in which VBA finds itself today. Having grown at an alarming rate over the past several years, the total backlog of pending cases is in the hundreds of thousands. With current and proposed FTEE levels, CP&E employees are being deluged by the enormous numbers of cases on their desks. Although these same employees adjudicated 6.3 percent more cases than the year before, we wonder at what expense? As cases become more complex, due primarily to the length of time it takes to process them, are veterans getting thorough reviews and accurate decisions? The large number of claims being sent to the Board of Veterans Appeals each year certainly tells part of the story.

As we wrote in our statement for the recent confirmation hearing for the new Chief Benefits Director, the matter of backlogged cases must be dealt with on a priority level. Given the many congressional objectives already mandated, coupled with the severe lack of funding for FTEE, this will not be an easy task. Only through a combination of improved ADP systems, the restoration of sufficient FTEE, and management initiatives that ensure every job function contributes to the improvement of services to veterans will VBA be able to reverse the present downward trend.

The administration has proposed an increase for CP&E of seven FTEE for 1991—the only VBA service to gain employees. This increase, from an appropriated level of 3,752 to that of 3,759 FTEE, is 358 FTEE short of the Independent Budget recommended figure of 4,117 for FY 1991. The Department has contended that seven additional FTEE, coupled with ADP improvements, will enable VBA to reduce the number of backlogged cases.

The Independent Budget has clearly proven that DVA's claim simply cannot be realized. On the contrary, in spite of management initiatives and interim ADP improvements, the number of backlogged cases has grown at a staggering pace primarily because of an insufficient number of FTEE. As an estimated 40,000 individuals leave active military duty over the next year due to cutbacks in DOD, the burden facing CP&E will become heavier still.

Mr. Chairman, we call upon the Congress to restore appropriate FTEE levels to VBA, as recommended in the Independent Budget, as quickly as possible. If VBA expects to improve service to veterans, as they have stated, the backlog must be stabilized in 1990 and the proposed number of FTEE for CP&E must be increased.

VETERANS SERVICES

As DVA management begins to employ the use of consolidation throughout the Department to improve efficiency, the mission of the Veterans Services Division (VSD) takes on an elevated level of importance within VBA. Representing the front line of benefit delivery within VBA, employees of the Veterans Services Division provide information and advice to veterans, assist with claims, conduct personal interviews, and answer hundreds of thousands of telephone calls.

As certain offices and services are regionalized to improve the efficiency of claims processing, localized veterans services must be maintained at sufficient levels to ensure that veterans and their dependents are able to have access to knowledgeable counselors and benefits experts.

Further reductions in this service will escalate two of the most glaring deficiencies within VBA. First, as stated in the Independent Budget, approximately 1.7 million veterans were unable to talk to a veteran benefits counselor in 1988 because they were unable to get through on the telephone. Clearly, this problem is due to inadequate budgets which have drained VBA's ability to respond to so many inquiries. A strong nationwide toll free telephone service is essential to maintain a reliable contact point for veterans needing benefits assistance and services.

Second, VSD's outreach service to those veterans who need it most has deteriorated significantly in recent years. Those veterans most vulnerable—the homeless, elderly, and disadvantaged—will suffer the most from reductions in VSD FTEE. In-office workloads have prohibited any semblance of adequate outreach efforts by the various VA regional offices. In some cases, even personal interviews in the office are restricted due to staffing shortages.

The administration's response to the situation in VSD is exactly the same as it was last year—VSD is being asked, once again, to accept one of the largest reductions of all VBA services. The proposed budget for FY 1991 decreases FTEE in Veterans Services by another 15 personnel. From an FY 1990 appropriated level of 2,081, this decrease will further aggravate the deteriorating quality of service that VSD is able to provide. In addition, the decrease further widens the gap between the administration's recommendation for VSD and that of the Independent Budget—2,276 FTEE for both FY 1990 and FY 1991.

This vital link to the veteran community must not be permitted to deteriorate any further. If service to veterans is to be improved, such improvements must include the restoration of adequate staffing levels for VSD. PVA strongly urges the Congress to accept the IB recommendation of 2,276 FTEE.

HOME LOAN GUARANTY PROGRAM

Nowhere in VBA have varying levels of FTEE had such an immediate impact on the ability of a service to perform its mission as in the Home Loan Guaranty program.

We have witnessed how 10 additional employees at the Houston regional office contributed significantly to the resolution of many potential foreclosures. Due to the increased number of employees, the cure rate of loans in Houston almost offset the default rate in that economically devastated area. In fact, it was once again demonstrated that if a loan guaranty employee cures just two loans, that person has saved the government the cost of his salary.

Nevertheless, the administration has responded by recommending no increase in the number of FTEE for the Rome Loan Guaranty service. While the Department claims that VBA must improve loan servicing, the required personnel simply will not be there to ensure that lenders and VA are fully implementing the provisions of the law.

Like the Veterans Services Division, VA Home Loan Guaranty needs employees as soon as possible. The administration's recommended number of 2,165 is well short of the 2,270 recommended by the Independent Budget. In addition, we understand the actual number of employees in Loan Guaranty is currently closer to only 2,000 FTEE. Although home loan legislation, such as the new Indemnity Program established by Public Law 101-237, should go a long way toward restoring financial solvency to this account, new legislation alone will not solve the problems of a service which has required massive appropriations to keep it afloat.

The bottom line is that it will take more people to improve the cure rate of loans that are in default and more people to ensure credit-worthiness, accurate appraisals, improved marketing of properties, and the adequate monitoring of major lenders—especially those who have been granted automatic approval authority.

Regarding the administration's proposed legislation for Loan Guaranty, attempts to decrease funding authority and outlays at the expense of veterans and service personnel is completely unacceptable to PVA. We strongly oppose any effort by the administration to require a downpayment of 4 percent on loans in excess of $25,000. This erodes the fundamental benefit concept of the program which the Congress has historically maintained for 45 years. We also oppose the administration's proposal to increase the new indemnity fee from 1.25 percent to 1.75 percent. Before the new program even has a chance to establish itself, the administration is asking veterans and active duty personnel to part with another half percent. This proposed increase in the fee, coupled with the proposed 4 percent downpayment, will certainly prohibit many otherwise qualified and deserving veterans from buying a VA guaranteed home.

VOCATIONAL REHABILITATION AND EDUCATION

The administration has, once again, proposed a decrease in FTEE for this critical service. The President's FY 1991 budget removes five more employees from a service that is currently overwhelmed by caseloads which are totally unacceptable in other Federal/State and private vocational rehabilitation programs. The total number of proposed FTEE, 640, is 74 fewer than recommended by the Independent Budget.

The seriousness of the large average workload, approximately 200 cases per counselor, can quickly be demonstrated by simply looking at the numbers. A service-disabled veteran must wait over 3 months from the time the initial application is filed until an interview can be held with a counseling psychologist. Another 285 days will pass before the completion of the veteran's rehabilitation program and the point at which he is considered successfully employed.

As a comparison, private firms engaged in rehabilitation counseling attempt to see a client within 72 hours of the initial contact. Every delay during the course of one's rehabilitation will, they believe, diminish the benefits of the service. In addition to an adequate number of FTEE, VBA's vocational rehabilitation efforts can certainly be improved with management initiatives such as those recommended in the case management study submitted in July 1988 by the Veterans Advisory Committee on Rehabilitation. It is essential that the Secretary and new Chief Benefits Director take action to enable this benefit program to be delivered by a cohesive and united team (including both VBA and VHS&RA), one with identical objectives, and one that can prioritize vocational rehabilitation within the spectrum of all benefit programs and medical activities.

Mr. Chairman, the rehabilitation of disabled veterans provides an extremely beneficial service to both the individual and the Nation as a whole. PVA urges you to reject the administration's proposed decrease of five FTEE and restore a total of 714 needed to reduce average workload for counselors and delays for veterans.

In concluding our remarks about the Veterans Benefits Administration, it is obvious that the President's proposal to support funding for 12,334 FTEE in FY 1991 falls far short of the 13,389 FTEE recommended in the Independent Budget for next fiscal year. Most important, however, is an immediate increase of 734 VBA FTEE's through an FY 1990 supplemental appropriation costing $25 million. This is the number needed to stabilize the existing workload in VBA in order that subsequent staffing levels can restore acceptable service to veterans.

BOARD OF VETERANS APPEALS

We do not believe the modest staffing increase submitted for the BVA will be sufficient to significantly reduce the Board's response time on cases under appellate review. As the numerous problems mentioned above in VBA continue to contribute to the ever-increasing number of appeals received each year by the Board of Veterans Appeals, both backlogs and response times have suffered. Additional BVA responsibilities created by the establishment of the Court of Veterans Appeals (COVA) will require increased administrative support as well.

Although PVA refrains from recommending a specific level of staffing for the Board, we do believe there is merit in the Board's own analysis that for every FTEE, the Board can decide 100 cases. We have been advised that if the rate of case receipts for the past quarter is annualized, BVA can be expected to receive 52,000 cases this year! At a time when the staff of VA General Counsel and VA Congressional Affairs have both enjoyed substantial staffing increases, we believe more attention should be given to the needs of BVA. We encourage this committee's vigorous oversight of BVA's activities as the Board attempts to reduce response times.

Increased productivity must not be accomplished at the expense of thorough and fair decisions. It will also be important to monitor the relationship of BVA, General Counsel, and COVA as Public Law 100–687 is implemented.

COURT OF VETERANS APPEALS

Enactment of judicial review legislation and the establishment of the Court of Veterans Appeals was a major priority for PVA during the 100th Congress. We encourage this committee to ensure the prompt implementation of this important legislation.

Empowered to overturn VA findings of fact that are clearly erroneous as well as VA regulations or interpretations of law, the President's budget provides $8,960,000 to operate COVA. Although we are unable, at this time, to determine the adequacy of the new Court's funding level, it appears to be sufficient to accomplish the objectives as required by law. PVA does not endorse the transfer of funds from DVA's Medical and Prosthetics Research account to provide the necessary funding for the Court. We firmly believe that additional funds should be appropriated to accomplish the mission of COVA.

PROPOSED REORGANIZATION OF CERTAIN ACTIVITIES OF VBA AND VHS&RA—S. 2101 AND S. 2103

S. 2101

Mr. Chairman, S. 2101, which you introduced at the request of the administration would waive the waiting period requirement of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization involving the Loan Guaranty Division at the Togus, ME Veterans Affairs Medical and Regional Office Center.

This proposal would close and transfer the Home Loan Guaranty operation at Togus, ME (10 FTEE), the Loan Guaranty Divisions at the Boston, MA Veterans Affairs regional office (9 FTEE), and Hartford, CT regional office (6 FTEE) to a consolidated "New England Loan Guaranty Division" at Manchester, NH. PVA has no objection to this proposal if the committee determines that management improvements can be achieved without reducing direct levels of service for veterans in this area. PVA encourages the committee to evaluate projected home loan guaranty workload in each State and the potential impact changing economic conditions could have on workload in each of the present loan processing divisions to make certain that consolidation will not alter the level of direct services provided to the veteran population.

S. 2103

S. 2103, introduced by request of the administration, would waive the reporting period requirements of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration (VHS&RA).

The proposal would implement an administrative reorganization within the Department of Veterans Affairs to reduce the number of regional field offices of VHS&RA from seven to four. In conjunction, the proposal would entail the elimination of the 27 medical district management offices by March 31, 1990. This latter proposal is not subject to the reporting requirements of section 210(b) and can be achieved unilaterally by the Department without the review and approval of the House and Senate Committees on Veterans' Affairs. Again, Mr. Chairman, PVA has no objection to the proposed consolidation of the medical regions from the present seven to four if it can be clearly demonstrated that management and line authority will not be compromised in the process. Now that the Medical District Initiated Planning Process has been abandoned and the 27 medical districts themselves scheduled to be eliminated as a collateral part of the regional consolidation, we also concerned over what course future health care planning will take within the system.

We have long advocated that management efficiencies can be achieved in most all of the Department's activities to streamline and reduce the cost of decision-making, and, in the end, improve services to veterans. The DVA's proposal to reduce the number of medical regions from seven to four is fostered by this same desire. The Secretary has made clear the resulting cost savings from this consolidation would be applied to improve direct health care services for veterans throughout the system. If the consolidation is approved, we suggest the committee carefully track how these savings in dollars and FTEE will be applied to improve direct patient services. At the same time, the committee should scrutinize remaining resources at the regional office level to make certain that the four remaining offices, whose missions have been enlarged to oversee the operation of additional VA medical centers over a greater geographic area, have sufficient staff and budgets to perform adequate management and objective planning functions over a system that was previously controlled by 7 regional offices and 27 medical district offices.

Mr Chairman, this concludes my testimony, I will be happy to respond to any questions you might have.

THE FY 1991 INDEPENDENT BUDGET
A Summary

This is the fourth consecutive year that AMVETS, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars (VFW) have collaborated to recommend a budget to Congress that accurately reflects proper appropriation levels to meet the needs of all eligible veterans. In this FY 1991 Independent Budget proposal, these four veteran service organizations (VSOs) present recommendations for fiscally prudent responses to veterans' *real* needs for benefits and services.

As we view veterans' programs this year, it is clear that the challenges the Independent Budget must address, to assure entitled veterans their benefits, are growing in intensity and volume. Significant service delivery problems result in denial of benefits, without due process, to thousands of veterans. The ultimate beneficiary of VA-administered programs – the veteran – is receiving increasingly inadequate and inappropriate service. The department's major problems in meeting the legitimate needs of veterans are rooted in insufficient funding and poor management of the funds that are appropriated.

These problems will not disappear until the department has a more reasonable budget, and major changes are made in the allocation process and how available resources are utilized. The VSOs will continue to press for the resolution of these issues.

Should Congress and the Administration not address and resolve these problems, veterans will suffer further adverse consequences. For example, the medical care system, which many veterans depend upon for their health care, will experience irreparable damage. Typical is the critical need to avoid the expected exodus of VA physicians after October 1990 – as referenced on page 78. This is the tenth anniversary of *Public Law 96-330*, which represents the last provision of special pay for physicians and dentists employed by the Department of Veterans Affairs. Over the past ten years, the purchasing power of physicians' and dentists' income has decreased 25 percent. Absent the provision of a significant increase in pay at this time, many will be forced to leave the program. Such a loss in quality of health care for eligibile veterans must be avoided. Should the situation persist, VA will become a target for dismantlement — a bleak prospect for needy veterans. And veterans who are entitled to compensation, pensions, educational assistance and rehabilitation counseling will wait for months before their claims and benefits inquiries are even considered. This, in turn, will invite further inquiry from anxious veterans who are concerned about their eligibility for benefits. Thus, the inability to produce work in a timely manner creates *more* work for an overburdened staff.

During the previous three budget cycles, we pointed out the severe problems of processing veterans' requests for benefits; accurately projected the ramifications of deteriorating services in the veterans benefits area; and presented factual data on deteriorating quality of and barriers to the Medical Care program due to funding deficiencies. We distributed these assessments and predictions, and our proposed solutions, to the Department of Veterans Affairs and other interested parties. For example, every member of Congress receives a copy of the Independent Budget, as do the Congressional staffs of the Budget, Appropriation and Veterans Affairs committees. All key VA staff receive a copy of the Independent Budget. The VSOs have made extensive efforts to ensure that the message reaches those who have the power to make a difference. We have met with Congressional leaders, and presented testimony to the appropriate committees. We have made progress, but not nearly enough progress to ensure sufficient funds to support VA programs properly and meet all eligible veterans' needs.

In a December 6, 1989, article in the *Daily Press*, Hampton, Virginia, Secretary Derwinski stated that the veterans' service organizations are not likely to be satisfied with the FY 1991 budget request he negotiated with the Office of Management and Budget (OMB). He also stated that veterans' groups "are never satisfied nor [as advocates for veterans] should they be."

We have conducted in-depth analyses of VA programs and have proposed cost-effective solutions that are based on those analyses and designed to meet veterans' needs today. Further, we have proposed plans of action to meet veterans' future needs. In the end, we are not asking for more – we ask only for that to which veterans are entitled – and we insist on delivery of good and timely service to all veterans. VA did not meet our objectives in FY 1989, it will not meet them in FY 1990, and, from Secretary Derwinski's perspective, VA cannot meet them in FY 1991 unless the Administration and Congress take more than token steps to recognize veterans' needs and to meet their obligations to veterans.

Over the past four years, the question that has arisen from our delineation of need is, where do Congress and the Administration place veterans in the priority scheme for funding? For example, every other federally funded health care program in each of the past five years has received a considerably larger percentage of increase in appropriations than the VA health care program (see Chart 1). Why? Are veterans less deserving? Who is our advocate in the Administration if not the Secretary of Veterans Affairs? And who in Congress is responsible for assuring that veterans' needs are met? The Veterans Affairs committees are concerned with oversight and enabling benefits legislation. The Appropriations committees are concerned with a host of issues that apparently place low priority on veterans' concerns. The Budget committees do not deal with VA budget details. Since there is no one point in the Congressional structure that can be held accountable for the VA budget, the VSOs must turn our attention to the individual members of Congress and address the funding issues at the local (Congressional district, VSO chapter) level. In the following paragraphs, we outline the major challenges that veterans face in this time of budget austerity and recommend the FY 1991 funding levels or actions necessary to meet these challenges.

The FY 1991 Independent Budget presents our foremost concerns for each major account -- General Operating Expenses, Veterans Benefits, Medical Programs, and Construction Programs.

GENERAL OPERATING EXPENSES

This account funds administrative activities and support systems of the Veterans Benefits Administration (VBA), the National Cemetery System (NCS) and General Administration of the department.

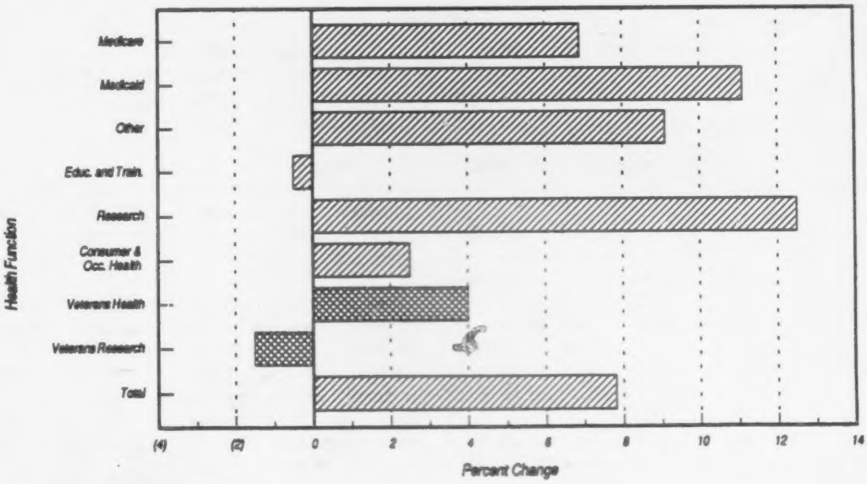
VETERANS BENEFITS ADMINISTRATION

Because of a decade of inadequate budgets, VBA does not have the resources to provide adequate delivery of benefits and services to veterans and their dependents. During FY 1989, service to veterans predictably continued to deteriorate from already unacceptable levels, as evidenced by the following:

o The backlog in compensation and pension claims has skyrocketed from 167,000 in October 1987 to more than 650,000 at present.

o Timeliness and quality of case adjudication has deteriorated, with almost one-third of the original compensation claims taking more than six months to complete.

CHART 1
Federal Health Budget
Average Annual Percent Change -- FY 1985-1989



Data Source: FY 1990 Budget of the United States Government
Table excludes FY 1989 supplemental appropriations

o Program delays are prevalent, such as when disabled veterans who apply for vocational rehabilitation must wait, on average, 100 days before a vocational rehabilitation counselor interviews them.

o More than one million veterans cannot contact VA, because of busy telephone lines or being placed on hold for long periods of time.

o Veterans default unnecessarily on home loans, at great cost to them and the Government.

These problems will worsen if budgetary support is provided at a "current-services" (or lower) level. During the past year, the VSOs have observed, with approval, a renewed commitment by VBA management to improve service to veterans by innovative use of available, but insufficient, resources. If Congress has the political will to provide the budgerary support needed to restore adequate service to veterans, the VSOs are confident that the additional resources provided will be used effectively.

The VSOs have formulated a long-range plan for the restoration of good service to veterans, which can be successfully implemented with relatively modest budgetary increases. The plan requires:

(1) an immediate increase of 734 VBA FTEEs, and maintenance of the increased employment level until good service is restored;

(2) ongoing productivity improvements through short-term automated data processing initiatives and management activities focused completely on improving service; and

(3) implementation of an integrated, VA-wide automated data processing system by FY 1994.

The VSOs' specific recommendations for implementing the plan within VBA are:

o *Executive Direction* - Although no increase in FTEEs is recommended, VBA management is urged to analyze work processes and procedures and the functions or tasks performed by employees, especially those in so-called staff positions, to ensure that all activities are focused on improving service to veterans. Employee performance plans should be revised accordingly. An important corollary is the need to remove bureaucratic barriers to the implementation of good ideas.

o *ADP Management* - This component appears to be staffed adequately. The VSOs are encouraged by the change in direction that has occurred recently in the planning, procurement, and implementation of improved automated data processing systems. The VSOs are recommending that VBA be given complete authority and responsibility in the areas of planning, procuring and implementing automated data processing systems designed to support veterans' benefits and service delivery.

To address the service delivery problems cited above, there is an immediate need for additional staffing in several VBA components.

o *Veterans Services* - To reduce the abandoned call rate and expand outreach programs to veterans will require 195 additional employees. Improvements are required in the computer and telecommunications systems.

o *Compensation, Pension and Education* - Our goal is that VA stabilize and reduce the claims backlog and meet all VBA acceptable timeliness standards by the end of FY 1991. This will require an additional 365 employees -- 242 to stabilize the backlog, plus 123 to systematically begin to reduce the backlog to reasonable levels.

o *Vocational Rehabilitation and Counseling* - We seek to increase FTEEs by 69, to reduce the vocational rehabilitation specialist case load to an average of 135 veterans. This compares to 60 cases per specialist in other state/Federal rehabilitation programs.

o *Loan Guaranty* - We recommend increasing staffing by 105 employees, to improve the cure rate percentage of loan defaults from the 1989 level of 74 percent to the 1983 level of 85 percent. This action will help veterans who default to solve the problems that created the default environment, and enable the veterans to continue home ownership. It also will generate significant program savings -- $335,000 for each additional employee.

The additional 734 FTEEs are needed now merely to stabilize the existing workload and should be provided by an FY 1990 supplemental appropriation. *The annualized cost of the supplemental appropriation is $25 million, or less than a dollar for each of the nation's 27 million veterans.*

The recommended VBA staffing level to be provided by an FY 1990 supplemental appropriation should be maintained in FY 1991. For FY 1991, the VSOs also recommend an increase ot 55 FTEEs in VBA's Support Services component over the FY 1990 appropriated level. If less staff is needed in Support Services because of productivity improvements, management should allocate FTEEs to other understaffed VBA components.

NATIONAL CEMETERY SYSTEM

The National Cemetery System (NCS) (1) inters deceased veterans and deceased active duty members of the Armed Forces, their spouses, and certain dependents, in national cemeteries that have available grave space, (2) provides headstones for these burials in national cemeteries and for burials in non-VA cemeteries and (3) administers the program of Grants for Construction of State Veterans Cemeteries.

We recommend that, for FY 1991, Congress increase NCS staffing by 92 employees, and that $12.4 million be appropriated to alleviate the current equipment backlog, accommodate normal salary increases, purchase needed new equipment, maintain equipment and support workload growth.

GENERAL ADMINISTRATION

Under General Administration, GOE appropriations fund the activities of the Office of the Secretary, General Counsel, the Board of Veterans Appeals and the Board of Contract Appeals. The functions of the offices of the six Assistant Secretaries are also funded under GOE. General Administration is being restructured because of organizational changes occasioned by VA now being a cabinet-level department.

For FY 1991, the VSOs recommend an increase of 80 FTEEs over the FY 1990 appropriated level. However, as in VBA, we recommend that VA analyze and, as necessary, restructure General Administration functions and positions to ensure that work activities focus on improving service to veterans.

BENEFITS PROGRAMS

Veterans Benefits covers four major activities: Compensation and Pensions (C&P); Readjustment Benefits (RB); Veterans Insurance and Indemnities (VI&I); and Loan Guaranty Revolving Fund (LGRF). Benefits payments from these accounts result from determinations that veterans, their dependents and survivors meet eligibility requirements set by law. When those requirements are met, benefit payments are non-discretionary -- that is, the Government must make the predetermined payments.

Recommendations that will require more than non-discretionary appropriations for benefits payments are:

o A benefits programs cost of living adjustment (COLA), effective December 1, 1990, equal to the COLA applied in other Federal programs. The VSOs are prepared to support a reduced or delayed COLA as a deficit reduction method *only* if it is applied to all Federal programs, without exception.

o An FY 1990 supplemental appropriation of $60 million for Veterans' Job Training Program. *P.L. 100-322* authorized funding and $60 million for this account for FY 1988 and FY 1989, and extended the program to September 30, 1989. However, the Administration did not request appropriations to fund this legislation.

o Despite effective Congressional and VA actions during the past year, placing the Loan Guaranty program on sound footing will require an appropriation in FY 1991, because of carry-over problems. The VSOs recommend an appropriation of $512.2 million.

MEDICAL PROGRAMS

Medical Programs consists of five funding categories: Medical Care, Medical and Prosthetic Research, Medical Administration, Grants for Construction of State Extended Care Facilities and Grants to the Republic of the Philippines.

Major concerns with the Medical Care account that the FY 1991 Independent Budget addresses are summarized below, along with our recommendations.

MEDICAL CARE

This account supports all medical center level health care activity, including direct care and contract care provided to veterans. The VSOs are concerned about the following issues:

o inadequate and ineffective strategic and operations planning for the health care system.

o inappropriate health care delivery because of growing misuse of the ill-conceived resource allocation system.

o failure to adequately identify or address medical care program funding deficits.

o growing evidence of quality erosion in medical care delivery.

o failure to change the system to accommodate the needs of a growing elderly veteran population.

o inability of needy entitled veterans to access appropriate health care.

o confusing entitlement to health care.

o growing threats to the continuity and integrity of VA's link to medical schools.

o development of various state programs to meet the needs of their medically uninsured and underinsured population -- including veterans.

This is a broad range of critical issues. Independent Budget recommendations for addressing the most serious of these concerns will require large funding increments. Medical Care's underfunding over a number of years (which the Independent Budget has pointed out for four years) has created severe problems in health care delivery. Yet the system must be sustained in a cost-efficient manner, so that entitled veterans have reasonable access to quality health care. The Independent Budget recommends the following actions:

o Provide the resources necessary to meet entitled veterans' health care needs.

--Support a resource base sufficient to meet veterans' hospital, outpatient and nursing home care needs.

--Assure necessary funds to expand outpatient programs.

--Clearly define the basic financial resources needed to operate the system to meet entitled veterans' needs, and protect that funding level in future years' budget development. In today's VA system, a basic funding level must be increased substantially every year simply to accommodate built-in costs.

o Expand programs needed to care for aging veterans.

--Develop the institutional capacity to meet more adequately aging veterans' long-term hospital care and nursing home care needs.

--Expand programs essential to older veteran care, such as Geriatric Research Evaluation and Clinical Centers, Geriatric Evaluation Units, Hospital Based Home Care, Respite Care, Hospice Care, Community Residential Care, and Adult Day Health Care. These programs cannot remain static in the face of our aging veteran population's growing needs.

o Re-evaluate each medical center's mission in the system, to reduce unnecessary duplication of services and limit program expansion. This will allow VHSRA to control costs more adequately.

o Eliminate the current resource allocation system, which has become a competition for funds between medical centers and regions (the veteran being the loser). The system has encouraged managers to use all available discretionary funds (equipment, travel, contract nursing home funds) to produce more medical center workload. This in turn increases the dollar-flow to medical centers since, in theory, higher workload volume means larger dollar allocations. As this happens across the system, the shrinking dollars are spread across greater workload volume. This reduces average reimbursement while it absorbs all the funds that VA would otherwise have used to purchase needed equipment, community nursing home care and beneficiary travel.

o Provide adequate support for the fight against the growing AIDS epidemic, so that VA does not divert funds from the basic medical program to meet the growing AIDS workload.

o Convert several thousand unused and unstaffed hospital beds to nursing home beds, and supply the staffing necessary to provide nursing home care.

To address this set of recommendations and protect the "current services" as defined in this Independent Budget will cost $13.4 billion in FY 1991, compared to the FY 1990 level of $11.3 billion. This means $2.1 billion in additional funding is required to prevent further serious damage to the veterans' health care system. This is a lot of money. But VA medical care programs were underfunded by $640 million in FY 1989, and we predict a shortfall of an additional $770 million in FY 1990. Underfunding has been a chronic problem since the late 1970s. The system is in crisis,and the only solution -- if the system is to survive in this time of dire need -- lies in adequate appropriations and sound management.

MEDICAL AND PROSTHETIC RESEARCH

Appropriations to this account support three types of research activity: medical research, rehabilitation research, and health services research. As noted in previous Independent Budgets, a number of issues concern the VSOs.

o The instability in funding sources has a negative influence on research programs.

--VA is unable to meet future commitments for research projects that take a number of years to complete.

--Research teams lack stability.

o The reduction in real dollars over the past five years has reduced ability to fund research proposals deemed meritorious by panels of expert peers.

--The number of research personnel have declined from 4600 in FY 1984 to 3900 in FY 1990.

--The percentage of meritorious projects that are funded has declined from 61 percent in FY 1984 to 40 percent in FY 1990.

--Prospective investigators will not pursue VA research goals, but seek other sources of research support.

To address these problems, the authors of this Independent Budget recommend the following actions:

o Clearly define the current services base for medical research, and protect that funding level.

o Establish an additional 50 positions for the research development career program.

o Replace the FY 1988 budget reduction in rehabilitation research.

o Provide funding to evaluate rehabilitation research products for their use in commercial development and marketing.

o Direct some portion of available resources to medical care facility realignment, and assess the impact of various states' insurance programs for the medically indigent on the VA health care system.

The total recommended appropriation for the Medical and Prosthetics Research program is $255 million, which represents approximately 2 percent of the Medical Care program. This is a necessary investment in the future, yet it is considerably less than most other organizations devote to research.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES

This appropriation supports the Central Office staff of the Veterans Health Services and Research Administration (VHSRA), professional in-service training and various health professions scholarship programs.

The VSOs' principal concern is the continuing decline in staff in recent years, to levels below which Central Office operations have become inefficient. This decline is exemplified by:

o Inadequate and ineffective short- and long-term health care system planning.

o Lack of a comprehensive quality control program for medical care.

o The need for more effective VHSRA leadership and management.

To address these problems, we recommend:

o An audit of VHSRA Central Office and regional office organization by an independent private sector firm.

o Sufficient funds to support continuing education and scholarship funds for training of health care professionals.

The total cost of these recommendations is $63.4 million for FY 1991.

CONSTRUCTION PROGRAMS

Three appropriations finance VA's construction activities: Major Construction finances projects costing more than $2 million; Minor Construction supports projects of less than $2 million, and the staff who plan and supervise construction activities; and the Parking Garage Revolving Fund provides parking at VA facilities.

Issues of concern the VSOs have addressed in this Independent Budget are:

o the implementation of a costly, severely flawed Facility Development Plan program as the basis for determining medical center construction needs.

o absence of a structured analytical process for establishing national major construction priorities.

o long time-lines (as long as ten years) to complete major construction projects.

o excessive design costs, due to inadequate planning and consequent project recycling and changing requirements.

o lack of an adequate number of nursing home beds, to meet projected demand for such care.

o poorly maintained, aging medical centers.

To address these issues, the VSOs' Independent Budget recommends the following:

MAJOR CONSTRUCTION

In the absence of a sound planning program, and given the need to update the medical centers, we recommend a $666 million appropriation for Major Construction projects consistent with the department's Five-Year Plan. This appropriation would accommodate:

- four new 120-bed nursing homes.

- enhanced funding for Advanced Planning and Design.

- funds to acquire land for national cemeteries in states that have none.

- the balance of funds to be used for medical construction requirements.

MINOR CONSTRUCTION

The VSOs' most urgent concern is the need to update and repair VA medical facilities ($210 million). Of this amount, the VSOs recommend that:

- $42 million be designated for converting 2,000 unused medical center beds to nursing home care.

- $5 million support VA regional office construction projects.

- $10 million support national cemetery construction projects.

- $60 million maintain VA construction staff at adequate levels.

CONSTRUCTION PLANNING

The VSOs urge that VA personnel take appropriate steps to establish national construction priorities and improve construction planning.

PARKING GARAGE REVOLVING FUND

The VSOs recommend a $19 million appropriation for the Parking Garage Revolving Fund.

PROPOSED LEGISLATION

The Independent Budget also proposes legislation needed to improve the program of benefits for veterans. This year, several proposals have been developed, four of which are designed to directly benefit veterans. We recommend:

- Providing Category A veterans with entitlement to the full array of VA health care services — inpatient hospital, outpatient and nursing home care.

- Mandating the establishment of a veterans' cemetery in every state.

- Amending the *Federal Torts Claim Act* to include contract health care providers acting in the course of their assigned duties.

- A one-time open enrollment period so that uninsured, eligible service connected veterans may purchase RH life insurance.

In brief, these are the Independent Budget proposals for FY 1991. AMVETS, Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars will be working in Washington to make certain these proposals get a fair hearing. Our ability to secure funding for VA programs and services from Congress during severe competition for every scarce Federal dollar will depend heavily on the combined efforts of every veteran and every other citizen who has a deep concern for those who have served in defense of this nation.

TABLE 1
VA Appropriations By Account
(dollars in thousands)

Appropriation Account	1989 Appropriation	1990 Appropriation	1990 IB Current Services*	1991 IB Current Services*	1991 IB Recommended Appropriation
GENERAL OPERATING EXPENSES (GOE) AND MISCELLANEOUS					
General Operating Expenses**	$784,216	$793,108	$835,255	$881,765	$913,793
Grants for the Construction of State Veterans Cemeteries	9,000	4,288	4,288	3,946	3,946
Office of the Inspector General	0	21,306	21,306	26,859	26,859
TOTAL GOE AND MISCELLANEOUS	$793,216	$818,702	$880,849	$912,570	$944,598
BENEFITS PROGRAM					
Compensation, Pension, and Burial Benefits	$15,460,581	$15,365,495	$15,365,495	$15,204,451	$15,204,451
Readjustment Benefits	619,812	497,813	497,813	502,500	502,500
Veterans Insurance and Indemnities	9,220	13,940	13,940	15,410	15,410
Veterans' Job Training Fund	0	0	60,000	0	0
Loan Guaranty Revolving Fund	778,100	313,500	313,500	512,200	512,200
Guaranty and Indemnity Fund	–	–	–	80,800	80,800
TOTAL BENEFITS PROGRAMS	$16,867,713	$16,190,748	$16,250,748	$16,315,361	$16,315,361
MEDICAL PROGRAMS					
Medical Care	$10,882,671	$11,325,706	$12,094,200	$12,919,600	$13,444,100
Medical and Prosthetic Research	210,241	212,652	235,000	245,800	255,000
Medical Administration and Miscellaneous Operating Expenses	47,909	45,397	50,900	53,030	63,530
Grants for Construction of State Extended Care Facilities	42,000	41,349	42,000	42,000	42,000
Grant to the Republic of the Philippines	500	492	500	500	500
TOTAL MEDICAL PROGRAMS	$11,183,321	$11,625,596	$12,422,600	$13,260,930	$13,805,130
CONSTRUCTION PROGRAMS					
Construction, Major Projects	$363,040	$408,542	$408,542	$408,542	$666,300
Construction, Minor Projects	111,596	111,937	111,937	111,937	285,450
Parking Garage Revolving Fund	26,000	28,543	28,543	28,543	19,000
TOTAL CONSTRUCTION PROGRAMS	$500,636	$549,022	$549,022	$549,022	$970,750
TOTAL APPROPRIATION	$29,344,886	$29,184,068	$30,103,219	$31,037,883	$32,035,839

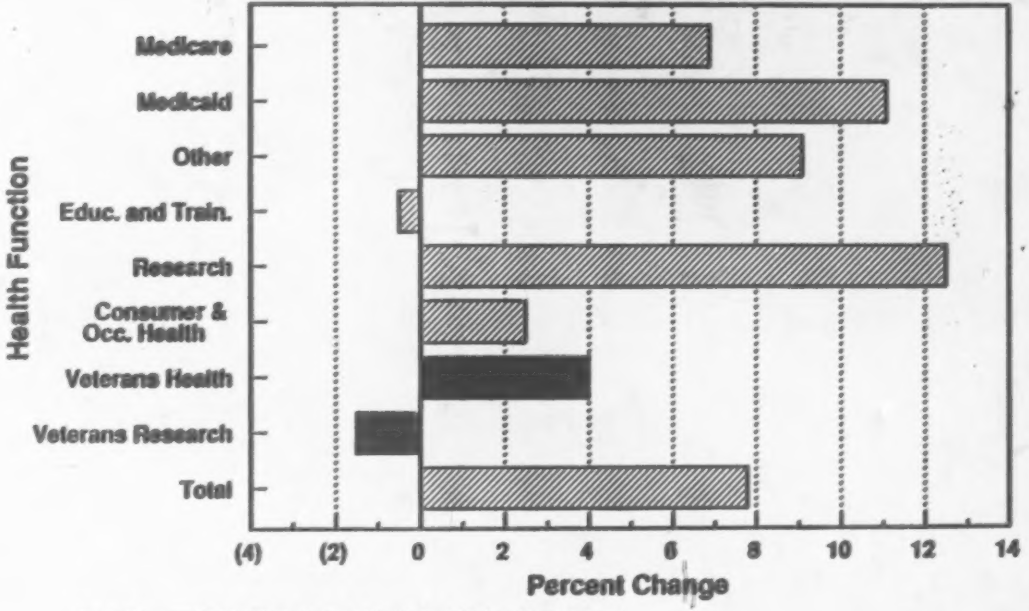
*Funds necessary to maintain services at the FY 1988 level

**Independent Budget figures do not include major appropriations items such as ADP and non-ADP equipment purchase and maintenance.

ATTACHMENT A

Federal Health Budget

Average Annual Percent Change FY 1985 - 1989



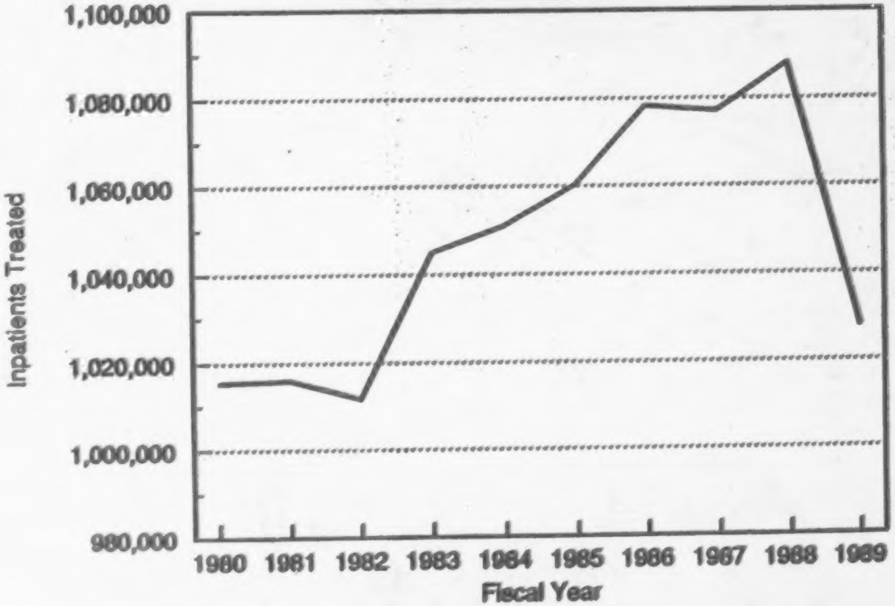
Data Source: FY 1990 Budget of the United States Government
Table excludes FY 1989 supplemental appropriations

ATTACHMENT B

ATTACHMENT B

VA Hospital Inpatients Treated

FY 1980 -1989



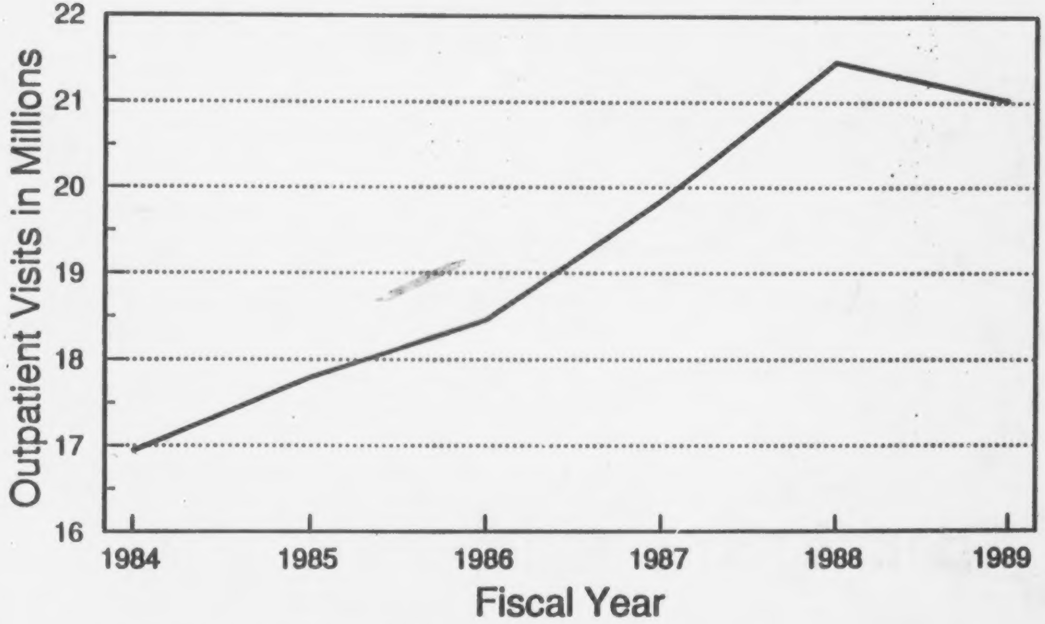
Data Source: Dept. of Veterans Affairs

ATTACHMENT C

ATTACHMENT C

VA Staff Outpatient Visits

FY 1984 - 1989



Data source: Dept. of Veterans Affairs

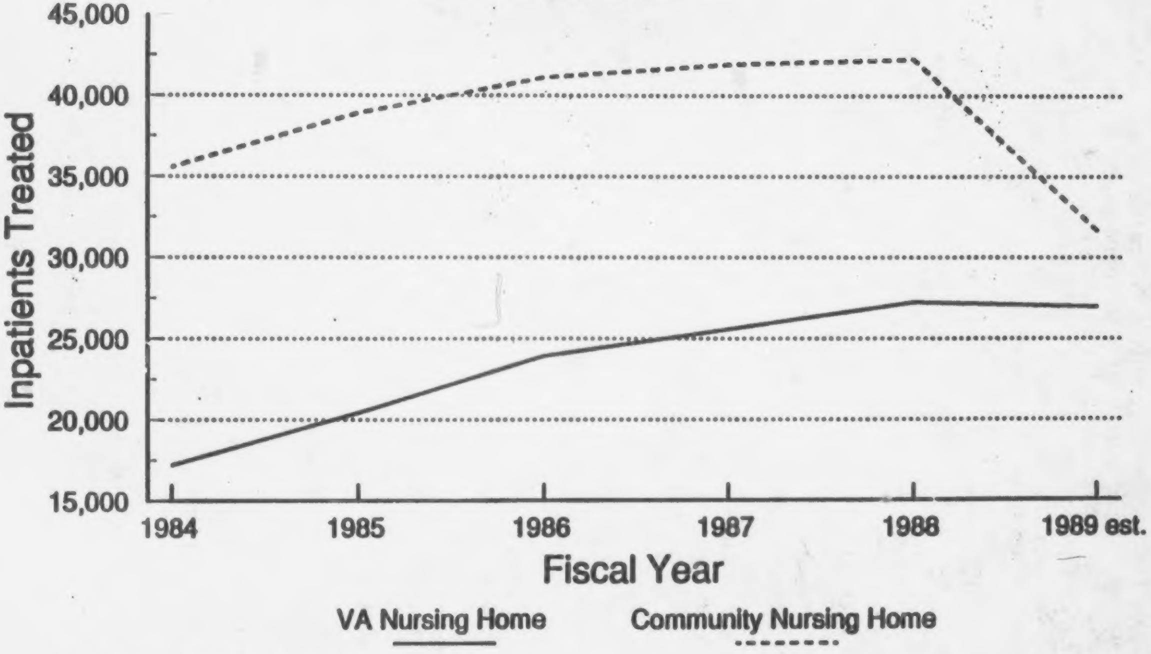
ATTACHMENT D

ATTACHMENT D

VA Nursing Home Patients Treated

Fy 1984 - 1989

Community and VA



Data source: Dept. of Veterans Affairs

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the committee, good morning. I am Dr. Robert Waldman, Dean of the University of Nebraska College of Medicine in Omaha, NE. I wish to thank the committee for the opportunity to appear before you and share with you my concerns about the funding needs of the Department of Veterans Affairs health-care system and the inadequacy of current resources for the Veterans Health Services and Research Administration (VHS&RA). I am a member of the Council of Deans of the Association of American Medical Colleges (AAMC) on whose behalf I have been invited to testify.

The AAMC represents the Nation's 126 accredited medical schools and their students, 92 professional academic societies, and 420 major teaching hospitals, including over 70 VA medical centers. Currently, 139 VA medical facilities are affiliated with 103 medical schools. This fact shows the strong ties between the AAMC and member institutions with the VA.

The basis of affiliation agreements is a model for public-private partnerships. Since the end of World War II medical schools and the VA have enjoyed a mutually beneficial relationship. Such arrangements have improved the quality of care provided to veterans and play a critical role in staffing VAMCs with outstanding health professionals. More than 30,000 medical residents and 22,000 medical students receive some training in the VA each year. Many of the physicians trained in the VA spend much of their careers in the system. Thus, affiliation agreements serve an indispensable function in recruitment. In addition, academic affiliations stimulate the work environment and offer access to individuals and resources which promote high morale and staff retention. Affiliations agreements can be thought of as symbiotic relationships that simultaneously benefit the mission of the VA and the training of the Nation's future health-care providers.

The AAMC also recognizes the important role the VA plays in the national health-care delivery system. As you know, the VA operates 172 medical centers, 231 outpatient clinics, 117 nursing home care units, and 27 domiciliaries, making it the largest health system in the Western World. Through this network, the VA provides access to care for millions of veterans in need of medical attention. In an era of rising costs of health care and efforts to shrink the Federal budget deficit, the VA's role in providing access to care has increased in importance. This comes at a time when the VA has faced severe budget shortfalls. I am concerned about the kind of measures the VA will need to take if adequate funding is not authorized for FY 1991.

The $12.3 billion medical care appropriation contained in President Bush's FY 1991 proposed budget is encouraging. It acknowledges the need for sharply increased funding by providing a $1 billion increase over the authorized FY 1990 spending level. However, even $12.3 billion will not allow VHS&RA to recapture past losses and maintain a high quality, well-balanced program.

The VA currently faces a situation for FY 1990 in which supplemental funding is necessary. The $11.3 million provided for veterans' medical care will not meet the needs of the program. I commend you, Mr. Chairman, for requesting $252 million in supplemental appropriations. The AAMC supports your efforts and those of your colleagues to obtain additional funds for FY 1990.

The President's proposed FY 1991 appropriation for the VA research program of $198 million represents a real cut of $14 million from FY 1990. Funding at such a level fails to meet even the most basic needs to sustain this important program. Secretary Derwinski has justified this cut by pointing to the increase in the medical care account. It is important to note that research funding supports the VA's patient care mission. The two programs should not be played against one another. The research program serves a vital function in the recruitment and retention of physicians who provide the highest patient care and conduct research. I am frequently reminded by the Chief of Staff of the Omaha Veterans Affairs Medical Center (VAMC) that the veterans at that facility receive their medical care from the same academic physicians who provide care at our University Hospital. This wouldn't be the case without the VA research program and the VA-University partnership.

Finally, the President's budget maintains the same level of funding in FY 1991 for health professional scholarships as was appropriated in FY 1990. In effect, this important program also lost spending power. I am deeply disturbed by the lack of commitment shown in these areas of the President's budget and by the impact that would result. I respectfully urge Congress to rectify these shortcomings in the President's proposed budget.

In the interest of publicizing the needs of the VA, the AAMC has joined a coalition of organizations who support increased funding for the VA's medical care and health research programs. This group, the Friends of the VA, advocates an alternative to the FY 1991 budget proposed by President Bush. The AAMC endorses the Friends of the VA's FY 1991 recommendations of $13.4 billion for medical care and $268 million for research. I request that the entire text of the Friends of the VA proposal be included in the official hearing record.

The $13.4 billion medical care appropriation proposed by the Friends of the VA would enable the VA to fulfill their mandate of providing quality health care to eligible veterans. For instance, funds would be available to fill long-vacant staff positions, depleted supplies would become a thing of the past, and out-dated equipment could be replaced. This funding level also recognizes the costs realized by the VA in treating AIDS patients. Last year, the VA treated 7 percent of all the Nation's AIDS patients, at a cost of $130 million. However, the VA was allocated a total of only $55 million for AIDS care. I would urge Congress to allocate to the VA a larger share of the general Federal funds designated for treatment of patients diagnosed with this tragic illness.

Funding of $13.4 billion would furnish the VA with some of the resources necessary to begin to adapt to the future needs of veterans. Specifically, excess hospital capacity could be converted to extended care services, more ambulatory services could be opened, and funds would be available for activation of newly-constructed facilities.

I cannot emphasize strongly enough the need to authorize a level of appropriations for VA medical care that preclude the need for midyear supplemental appropriations. You can well imagine the difficulty of operating any major organization, let alone a hospital, in the absence of clear budget forecasting. Funding that arrives late in the year does little to improve our ability to replace staff. Administrators can plan more effectively and patients can be served best by a well-balanced, yearlong spending plan.

In the area of research, a $268 million FY 1991 appropriation would allow the VA to operate at the 1985 level of effort. Between 1981 and 1989, the purchasing power of the VA research appropriation was cut nearly in half. This cut has meant the loss of promising innovations in medicine that could prolong and improve life, as well as lead to cost savings in health care delivery. Further cuts, as proposed by the President, would lead to additional lost opportunities.

The presence of research dollars offers veterans valuable opportunities to participate in studies that involve the latest medical therapies and technology. The long-term benefits of such studies are enjoyed by veterans and the entire population. As I mentioned previously, the importance of research funding on recruitment and retention must not be overlooked. The chance to conduct research in a clinical setting attracts many outstanding physicians to the VA. Thus, research dollars can be described as a well-invested, highly-leveraged amount of money that reaps considerable returns. To protect the benefits of research and the role research plays in the VA's mission, additional appropriations, well beyond President Bush's FY 1991 budget proposal, must be authorized.

In past years, the VA has been fortunate to receive a generous transfer of funds to the research account from the Department of Defense. I do not want my support for this transfer to be misunderstood. However, I believe it would behoove the future stability and security of the system to receive appropriate funding through its own budget line item, rather than to be forced to continue to rely on the DOD.

At this time, I would like to share with you some experiences and observations from the VAMC with which the University of Nebraska is affiliated. Please keep in mind that many of my colleagues across the country share similar concerns. While we in academic medicine often refer to support for research and education, the main message relates to patient care. Simply put, VA hospitals suffer from a lack of resources necessary to provide reasonable quality, and sometimes quantity, of care to veterans. For the dean of a medical school this presents a serious two-pronged problem. First, I am concerned about the care veterans receive. Second, I am concerned about the setting where students are educated. In my professional opinion, lack of resources threatens to compromise each of these factors.

I serve both as Dean of University of Nebraska College of Medicine and as chairman of our area's VA Deans' Committee. While my institution is affiliated with VA facilities in Omaha and Lincoln, NE as well as Sioux Falls, SD, our main affiliation is with the Omaha VAMC. The Omaha VAMC is a 362-bed tertiary care hospital serving veterans who live in the eastern third of Nebraska, western Iowa, northeastern Kansas, and northwestern Missouri. Many other health professional schools share the University of Nebraska College of Medicine's affiliation with the Omaha

VAMC, including Creighton University's Schools of Medicine and Dentistry, University of Nebraska's Colleges of Dentistry, Nursing, and Pharmacy, St. Mary's College of Nursing, Clarkson College of Nursing, and various schools of allied health. The combined efforts of these academic institutions and the VA have been effective and beneficial to all involved.

While the University of Nebraska appreciates our VA affiliations and the role they play as a setting for medical education, we also bring to the VA health-care professionals of the very high caliber. In addition, the university provides about $1.5 million worth of support a year to the VA through factors such as subsidization of salaries.

BUDGET SHORTFALL

The FY 1990 budget of the Omaha VAMC places the hospital under serve stress. Over the past 4 years funding levels have not kept pace with inflation. In the current fiscal year alone we project an operating fund shortfall in excess of $1 million. The shortfall involves the pharmacy ($510,000); the operating room ($200,000); the laboratory, central services, prosthetics, and home oxygen ($150,000); the purchase of medical services in the community ($100,000); and a variety of other supplies and services ($249,000), including such essential items as prescription drugs, artificial limbs, pacemakers, and laboratory reagents.

NURSING HOME CENSUS

In order to meet FY 1989 operating expenses, the VA was forced to divert funds intended to provide care in community nursing homes. The average nursing home census decreased by nearly 50 percent, from 50 to 28 patients. The FY 1990 budget contains only enough support for a nursing home census of 28 patients. These limitations mean that veterans cannot be placed in nursing homes at the appropriate time. Until a nursing home bed is available, they are kept in an acute-care hospital bed, which exposes the patient to added risks, such as hospital infections and places additional stress on the already short-staffed nursing pool.

EQUIPMENT AND MAINTENANCE BACKLOG

The Omaha VAMC has unmet acquisition needs for many major equipment items. The hospital's equipment budget for FY 1990 totals $346,000, however $260,000 has been restricted so that it cannot be spent before August 1, 1990. Approximately $1.5 million in equipment requirements have been identified, some equipment as basic as replacing 156 antiquated manually operated beds, many of which simply do not function, serving as a source of discomfort to patients and frustration to the nursing staff.

Funds for maintenance and repair of the hospital building have also been restricted from use until August 1, 1990. Critical among these needs are $225,000 to remodel the cardiac catheterization laboratory. The x-ray equipment in that laboratory is unreliable and frequently fails, sometimes in the midst of catheterization. A new radiographic unit was ordered in August 1989 with funds provided by the FY 1989 supplemental appropriation. While the equipment is now available for delivery, it cannot be installed until the renovation is completed. We have markedly curtailed catheterization procedures and discontinued accepting referrals from other VA medical centers because of concerns for patient safety. Another $325,000 in projects have been deferred until August 1990 and an additional $500,000 of needed work has been identified but not funded.

PERSONNEL SHORTAGES

Funds available in FY 1990 are expected to support only 925 of the 964 FTEE employed 3 years ago. Moreover the 925 projected employment level can be maintained only by imposing a hiring lag of at least 6 weeks each time a vacancy occurs. Over the same period of time, the Omaha VAMC has functioned with substantially fewer employees than is commonplace in comparable community hospitals. The disparity in staffing levels is particularly noticeable for ancillary health personnel. Residents assigned to the VA consistently complain about the inadequate number of staff available to help provide timely care for veterans. Some of the most prominent staff shortages include:

1. Phlebotomists—Laboratory employees draw blood on the wards only once in the morning. If additional blood tests are required throughout the remainder of the day, the specimens must be obtained by medical students or residents. This practice detracts from their education.

2. Electrocardiography technicians—Such personnel are available only during daytime hours on Monday through Friday. If an electrocardiogram is required at other hours, it too must be performed by a medical student or resident.

3. Respiratory therapists—The number of respiratory therapists is not sufficient to provide treatments around the clock to the large number of patients with severe pulmonary disease. This often results in patient transfers to the intensive care unit, the only area where the needed therapy is regularly available.

4. Patient transporters—No patient transport service exists. The Omaha VAMC relies on volunteers who only work a portion of the day on Monday through Friday. At other times, a nurse (from the critically short supply) must be diverted from often more important duties in order to escort a patient.

Significant discrepancies extend to other employee categories ranging from ward clerks to clinical service secretaries to quality assurance technicians.

RECRUITMENT AND RETENTION

Great competition for health-care workers has had a dramatic impact on the Omaha VAMC. We currently face difficulties in the recruitment and retention of health professionals in fields including nursing, nurse anesthesia, physician assistance, occupational therapy, physical therapy, respiratory therapy, laboratory technology, and x-ray technology. The local VA has limited flexibility for timely response to issues such as pay, fringe benefits, flexible hours, day care centers, working environment, including availability of modern equipment.

PHYSICIAN COMPENSATION

I understand that Congress is considering legislation to revise special pay to recruit and retain physicians. The gap between VA compensation and that offered by competitors for physician services is ever widening. The 1989 Ouadrennial Report to the President prepared from information assembled by the Klemm Analysis Group addresses the disparity in physician compensation. However, the data used in formulating the recommendations contained in the report is now almost 3 years old and is in need of revision to reflect current realities. Three area deserve further attention.

1. Both the current and proposed Special Pay provisions discriminate against part-time physicians. Part-time physicians frequently provide essential services that otherwise would not be available at many VA medical centers. In closely affiliated medical centers, part-time status provides an opportunity for physicians to expand their expertise by participating fully in patient-care functions based at the university hospital. The part-time VA physician is expected to be as qualified and dedicated to the veteran as the full time. Discounting the value of their services to the veteran by 25 percent sends a signal that debases their worth. Offering a financial inducement for full-time employment is certainly understandable, but it should be separately identified as such and not done in a fashion which depreciates part-time services.

2. The clinical disciplines included in the category of Scarce Specialty should be expanded. In addition to specialized surgery, there are subspecialties of internal medicine for which recruitment is difficult and the compensation in the non-Federal sector quite high. These include cardiology, gastroenterology, pulmonary disease, dermatology, and allergy.

3. The level of Special Pay authorized by Public Law 96-330 has not changed in 10 years. New legislation should address the need for annual cost-of-living or other types of adjustment to keep pace with the market place.

RESEARCH PROGRAM

The role of research in recruitment and retention can scarcely be overemphasized. The VA's ability to attract and retain clinician-scientists is dependent upon reasonable availability of research funding. Researchers' contribution to achieving the highest level of quality patient care frequently goes unrecognized. VA research support has eroded over the past few years so that the potential benefits of sound and worthy research proposals are lost to due to lack of funds. Some programs run by well-established and productive investigators have been terminated because of cuts in research dollars. Younger investigators, in particular, have felt the adverse effect by the present financial situation.

COMPUTERS

Computers have become an almost indispensable component of health-care delivery. Nevertheless in the VA, access to computing and word processing is far behind the private sector. The larger "main frames" provide important patient information, laboratory data, pharmacy profiles, and other components of the VA's Decentralized Hospital Computer Program (DHCP). Of equal importance are smaller personal computers (PCs) which can stand alone or be part of a limited, internal network. Money for the latter devices is worse than inadequate, it is currently nonexistent. PCs can enhance a variety of functions such as the hospital infection control program; quality assurance tracking; analysis of provider-specific performance; physician credentialing and privileging; accountability and disposal of radioactive drugs used in diagnosis and treatment; algorithms for the diagnosis and treatment of certain diseases; and a large number of other activities.

These are only a few of many possible anecdotes which illustrate the stress under which the system is functioning.

If the situation in Nebraska is representative of the situation nationwide, and I have reason to believe that it is, I must conclude that the VA health-care system is in serious danger. Budget shortfalls threaten the VA's ability to maintain a well-balanced health-care system, able to deliver quality care to veterans. More than Band-Aid measures are needed, specifically an FY 1991 appropriation above the President's budget proposal.

I thank you for the opportunity to express my opinions. Of course I will be happy to respond to any questions which you may have.

PREPARED STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman and members of the committee, I am Thomas B. Horvath, M.D., Chief of Staff at the VA Medical Center in Brooklyn, NY, Associate Vice President for Clinical Affairs Suny Health Science Center at Brooklyn, Professor of Psychiatry Suny Health Science Center at Brooklyn, and a member of American Psychiatric Association's Committee on Veterans' Affairs. I am pleased to appear before you today on behalf of the American Psychiatric Association, a medical specialty society representing over 36,000 psychiatrists nationwide, to represent our views and share our concerns regarding the FY 1991 budget for the Department of Veterans Affairs Medical and Health Research programs.

The APA, a member of the "Friends of VA Medical Care and Health Research Coalition," concurs with their FY 1991 funding recommendations of $13 billion for medical care and $268 million for health research, and endorses the Independent Budget recommendation, compiled by Veteran Service Organizations, for VA medical care.

As you know, VA medical care programs were underfunded by $640 million in FY 1989 and the predicted shortfall for FY 1990 is $770 million. Underfunding has been a chronic problem in the VA. If quality care is to be delivered and unmet needs are to be addressed, the FY 1991 budget must be based on current services dollar amounts, rather than the inadequate FY 1990 appropriation. To provide the same level of services in FY 1991 as FY 1988, a medical care budget increase of $1.6 billion over the FY 1990 appropriation is required.

The President's budget recommendations for FY 1991 include an increase of $955.694 million for VA medical care. The total proposed budget of $12.3 billion would provide desperately needed funds for increased programming and staffing. We commend Secretary Derwinski's efforts to significantly improve the quality of health care for our Nation's veterans and suggest that the President's increased funding recommendations be incorporated into the congressional budget. However, it is important to recognize the bottom line—the President's budget does not fully meet the documented need for services. As physicians and spokespersons for those who too often cannot speak for themselves, we hope to provide you with a greater understanding of how critical delivery of psychiatric care is to veterans and how inadequate funding levels continue to place mentally ill veterans at risk.

The VA's psychiatric patient workload over the last 5 years has significantly increased. Since the implementation of the Resource Allocation Methodology (RAM), VA psychiatry has experienced a 21-percent increase in episodes of care and a 13-percent increase in the number of unique individuals treated. In 1988, the percentage of discharges for individuals suffering dual diagnosis conditions involving a serious psychiatric disorder and an alcohol or substance abuse disorder was 89 percent.

Yet, despite the increased census and an evidenced need for more complex treatment with a higher level of care, the proportion of VA funds distributed to psychiatry bed sections has declined.

The VA must reaffirm its mission to provide comprehensive psychiatric services to veteran patients who suffer from service-connected illness including: schizophrenia, post-traumatic stress disorder (PTSD), Alzheimer's disease and other dementia, alcoholism and other substance abuse disorders, and depression. In addition, the time to address the tremendous unmet needs of veterans suffering from mental illness is long overdue. We cannot and should not continue to stigmatize our mentally ill veterans and—as discussed later—the psychiatric physicians who treat them.

The following items represent what we consider critical areas of need for increased funding in the medical care and medical research programs; and, highlight achievements that make this a most appropriate opportunity to take advantage of our rapidly growing knowledge about the diagnosis and treatment of mental illness and of the dramatic advances in our scientific enterprise.

Recruitment and Retention of VA Psychiatrists

The VA is now facing a crisis in health-care delivery by psychiatric physicians. A 1988 survey of 160 VA medical centers, conducted by the VA Mental Health and Behavioral Sciences Services, documented an overall vacancy rate for psychiatry of 14.59 percent. As of December 1988, there were 1,860.63 psychiatric physician Full-Time Employee Equivalents (FTEEs) and 269 FTEE vacancies—29 were full-time Chief of Psychiatry vacancies, 189 were full-time staff and 50 were part-time staff. The vacancy rate for psychiatrists located in centers with large psychiatry bed sections, predominately located in rural settings, was 16.4 percent. In 1988, the situation was defined as critical. It now appears that VA psychiatric physician recruitment and retention problems have reached a breaking point that can only worsen as physicians opt to take advantage of increased retirement benefits available for the first time in October, 1990.

The National Association of VA Chiefs of Psychiatry recently completed their own recruitment and retention survey of VAMCs. The preliminary report determined an overall vacancy rate of 19.09 percent, indicating a dramatic escalation of the problem. Turnover rates exceed 16 percent per year, and in unaffiliated VAMCs, which have large numbers of psychiatric beds and are predominately located in rural areas, the turnover rate exceed 20 percent. Over 70 percent of Chiefs of Psychiatry responding indicated that the quality of care provided to their patients has deteriorated.

One major obstacle to recruitment and retention efforts is the VA's inablility to compete with State facilities, who have increased their starting salaries in an effort to address their own recruitment and retention problems. Many States offer a $100,000 starting salary for a 40-hour work week, with an "on-call differential." In contrast, the average starting salary for a VA board-certified psychiatrist is $75,000–$80,000. A lack of research opportunities, poor working conditions (including insufficent staff to patient ratios), and an inability to supplement earnings with outside practice, add to the ever-growing problem.

The President's budget request contains $38 million for physician and dental pay enhancement. It is our understanding that the VA recruitment and retention legislative proposal has not been sent to the Office of Management and Budget for approval. Therefore, we are unable to comment as to whether the proposed dollar amount is sufficient to address the problems of psychiatry. It is our hope that the legislation will provide funding to support our recommendations.

We recommend that efforts be directed toward a reclassification of VA psychiatric physicians, which would permit the implementation of a compensation system recognizing physician longevity and specialty, and that psychiatry be designated as a scarce speciality. In addition, psychiatrists should be provided enhanced research opportunities, such as the MIRECCs discussed below, and renumerated outside activities should be offered.

The importance of providing fully-staffed, well-trained psychiatric units in VAMCs across the country cannot be overemphasized. Scientific advances have served to increase the relationship between physical and mental health, increasing the danger inherent in misdiagnosis. Psychiatrists, as physicians, have the training and competence to provide a medical differential diagnosis and treatment plan. Psychiatric patients in VA facilities suffer a high incidence of co-morbidity and physical causes of mental disorders. A proper understanding of the diagnostic and treatment considerations that affect them is essential.

As you are aware, the Department of Defense is currently evaluating the possibility of establishing a demonstration program designed to train psychologists to prescribe psychotropic medications. The shortage of psychiatrists is a dangerous rationale for any substitution of medical education and residency training particularly in order to allow nonphysician psychologists to prescribe medication. No State allows a psychologist to prescribe medication. We strongly urge against any proposal supporting or endorsing such a plan for the VA. The recent NAVACOP survey indicates psychiatrists are currently coping by temporarily employing physician extenders, such as physician assistants and nurse practitioners or physicians without psychiatric training. Psychiatric physicians are the only health care providers who have sufficient knowledge and skill to address physical and mental evaluation, differential diagnosis and treatment planning, the knowledge and management of drug side effects and drug interaction, and the role of medication in bio-psychosocial continuum framework of care. Mr. Chairman, at this time I ask permission to provide for your hearing record our letter to the Assistant Secretary for Health Affairs of the Department of Defense which further amplifies this critical distinction in training between medical doctors and nonmedical health care professionals, as well as a copy of the recent resolution of the Executive Council of the Reserve Officer Association of America which underscores our firm position.

MENTAL ILLNESS RESEARCH

It is no secret that the funding level for psychiatric research in the VA is vastly disproportionate to the utilization of psychiatric services. A mere 17 percent of research support moneys were directed toward psychiatry in the first half of FY 1987 and the dollar amount for behavioral research represents less than 10 percent of the total VA research budget. The President's proposed budget cut of $14 million (which includes a reduction of 440 FTEE) would severely impair all research efforts in the VA and further restrict research of the mental illnesses that affect 40 percent of our veterans, including schizophrenic disorders, psychotic disorders, and serious organic mental disorders. Interestingly enough, in President Bush's FY 1990 budget he stated, "Basic biomedical research is a classic 'public good' which would go underfunded without Federal investment. U.S. investment advances the interest of the Nation and the world." The relationship between research efforts and clinical application will result in success in the war against disease and has significantly impacted the treatment of many mental disorders. However, our research efforts will not result in more cost-effective treatment and services for patients and their families if adequate resources are not provided.

We support the Friends of the VA funding recommendation of $268 million and once again request that the VA create a Mental Illness Research Service similar to research expressly mentioned in the statutory provision, section 4101(c), which establishes the VA's research mission. We believe that the creation of such a service with its own budgetary allocation would help to pursue more creative and cost-effective innovative treatment for veterans with mental illness.

The Independent Budget recommends 50 positions and $2.2 million to restore the number of individuals in training in the Research Career Development program. We support that recommendation, and emphasize that the training of professionals with expertise in the treatment of substance abuse is of critical importance to the VA. Eighty-nine percent of psychiatric patients, including those diagnosed with AIDS, PTSD, and the homeless, also suffer a dual diagnosis of substance and alcohol abuse. More professionals are needed to treat this large number of veterans.

In addition, the APA wishes to express its support for the creation of Mental Illness Research, Education, and Clinical Centers (MIRECCs). Research is on the threshold of a new understanding of the bases of major mental illnesses. For example, research on schizophrenia has encompassed a broad spectrum of sciences, from the most molecular of the biological sciences to the broadest of the behavioral. Establishing MIRECC's provides an opportunity for the VA, and the research community together, to participate in a state-of-the-art innovative process. It is a modest investment to make when one considers the monumental possibilities for improving care and treatment of veterans. We request initial funding of $3.125 million for the establishment of five MIRECCs.

Enhancing research activities in the VA affects quality of care and the ability to attract and retain qualified personnel by permitting opportunity for professional growth. It is our hope that the establishment of the VA blue-ribbon panel, comprised of recognized leaders in health care, biomedical research, health services research, other Federal agencies and veterans' service organizations, will seek to elevate the status of VA research and redefine the research mission to prioritize efforts in the area of mental illness.

Let me emphasize that mental and addictive disorders are real illnesses. Modern neuroimaging permits us to see living brain structure and activity and gives us graphic evidence that severe mental illnesses have demonstrated brain abnormalities. Neuroscience progress has been dramatic, but the best is yet to come in treatment breakthroughs.

GERIATRIC PSYCHIATRY

Perhaps one of the most significant health problems facing the country, and particularly the VA, is that of the elderly's mental health care needs. In November of 1989, the American Board of Medical Specialties approved the establishment of a formal certificate of added qualification in Geriatric Psychiatry, thus allowing the American Board of Psychiatry and Neurology to prepare an examination for added qualification in geriatric psychiatry. With the growth of the elderly population and the specialized problems associated with geriatric patients, geriatric psychiatrists serve multifaceted roles of consultant, diagnostician and clinician to elderly patients suffering from organic as well as other mental disorders.

By the year 2000, there will be 9 million men over the age of 65. Two of every three will be veterans, and while not all will be eligible for care in the VA, the VA is already experiencing an increase in the number of elderly cared for in its facilities. In 1988, 7 percent of all VA hospital discharges were elderly veterans with a primary psychiatric diagnosis, and an additional 20 percent of hospital discharges were elderly veterans with a secondary psychiatric diagnosis. In addition, VA nursing homes/domiciliaries discharged 24.2 percent of their patients over 65 with a primary psychiatric discharge and 55.3 percent with a secondary psychiatric discharge. Discharge data for elderly utilizing contracted care with community nursing homes shows that 68.7 percent had a primary psychiatric diagnosis and 69.5 percent had a secondary psychiatric diagnosis.

The President's budget proposes an additional $27.4 million and 428 personnel to expand nursing home and domiciliary care activities. We suggest that the effort to provide care to the elderly veteran be expanded to increase the number of Geriatric Research, Education, and Clinical Centers (GRECCs) from 12 to 17, as recommended in the Independent Budget. We also request that funding be provided for 25 additional geriatric fellowships in geriatric medicine, particularly for psychiatry, in an effort to address the evidenced mental health needs of this specific population. The APA also endorses the Independent Budget recommendations to improve extended care programs, including the establishment of Geriatric Evaluation Units (GEUs) at each VA medical center.

HOMELESS CHRONICALLY MENTALLY ILL VETERANS

We are all aware of the staggering number of homeless in this country. Of the estimated 750,000 to 3 million living in streets or shelters, it is estimated that between 18 percent and 51 percent are veterans. The VA's Homeless Chronically Mentally Ill (HCMI) program has served 19,661 veterans in 43 metropolitan areas in its 2 years of operation. These veterans represent some of the most severely ill. The second annual report revealed that 97 percent of those assessed were diagnosed with a psychiatric disorder. Of that figure, 55.2 percent were diagnosed with alcohol abuse or dependency, 18.4 percent with drug abuse or dependency, 12.3 percent with schizophrenia, 9.3 percent with PTSD and 9.3 percent with affective disorders. Many suffered with dual diagnoses. The current funding level of $15 million for the HCMI program provides for staffing levels of 2.2 health care professionals per site. An additional $10 million is needed to increase inadequate staffing levels and expand the program.

The APA supports the President's recommendation for seven additional FTEE for a new Compensated Work Therapy program for substance abusers and suggests that Congress take legislative action to expand this program which provides vocational skills to homeless veterans so that they can achieve independent living status.

AIDS AND AIDS RELATED COMPLEX (ARC)

The VA caseload for AIDS and AIDS Related Complex represents about 7 percent of the Nation's total caseload. The Veterans Health Service and Research Administration (VHS&RA) expects 4,260 new inpatients in FY 1991 and 3,300 readmissions from previous years. In addition, the VA will follow 7,500 outpatients. We concur with the Independent Budget recommendation for no less than a $60 million increment in the FY 1991 budget, and emphasize that the President's recommended $51 million increase over the FY 1990 level for AIDs treatment will not prove to be sufficient.

Mr. Chairman, we appreciate this opportunity to express our concerns and urge your support for adequate funding levels for veterans suffering from mental illness. They require and deserve the best quality health care available.

PREPARED STATEMENT OF THE AMERICAN FEDERATION FOR CLINICAL RESEARCH

My name is Elliott Fisher and I am a staff physician at the White River Junction VA Medical Center in Vermont and an assistant professor of internal medicine at Dartmouth Medical School. I am actively engaged in patient care, teaching, and health services research at the VA. I am pleased to be here today to express the views of the American Federation for Clinical Research regarding FY 1991 funding for the VA research program.

The AFCR is the Nation's largest organization of medical investigators. It is comprised of approximately 13,000 physician and nonphysician scientists who are engaged in virtually every area of medical research. Our membership includes many distinguished scientists—among them winners of the Nobel Prize in Medicine. The VA research program is of particular importance to the AFCR, as many of our members are staff physicians who conduct research and provide care to patients in VA hospitals.

I would not be practicing in the VA were it not for the VA research program. In 1985, when I was looking for my first faculty position, I chose the VA over other excellent opportunities. Why?

—First, my major research interest is the problem of assuring access to high quality medical care for disadvantaged populations. Working within the VA allowed me to pursue that interest directly.

—Second, in 1985, the White River Junction VA had an active health services research program and a senior investigator who could serve as my mentor as I began my career.

But now, the strong research program that drew me to the VA is threatened. Since 1985, we have operated under increasingly severe funding constraints and research opportunities have been drastically reduced. In 1985 the VA funded 722 merit review awards, but is expected to fund only 539 in 1990. Furthermore, the percentage of approved projects that receive funding has dropped dramatically—from 80 percent in 1985 to a projected level of 45 percent in the current fiscal year. In other words, just 5 years ago a VA researcher who had written a meritorious proposal had an 80 percent chance of receiving funding—pretty good odds. Today that same high quality proposal would have a less than even chance of receiving support.

This situation is unfortunate because an adequately-funded research program benefits VA hospitals in many ways:

—the research program and academic affiliation create an intellectually-stimulating environment that fosters good medical care;

—the opportunity to conduct research enables the VA to recruit and retain outstanding health professionals;

—the research provides the opportunity for veterans to participate in research studies of promising new treatments;

—the research program can uncover strategies for reducing the escalating health-care costs of such great concern to all of us, such as the examples listed in appendix 1; and

—investing in health policy and health services research will improve our understanding of the current role of the VA in the health-care system. (How can we plan the future of the VA health-care system without knowledge of how well the system is working now?)

Frankly, what made the VA an appealing career option for me and many of my colleagues was the opportunity to conduct research. A recent study conducted by the Klemm Analysis Group confirms this impression. Rebecca Klemm, who was responsible for the study, has stated publicly that VA physicians in general reported that research opportunities were the most important factor in adequate recruitment and retention. Consequently, it comes as no surprise that as opportunities for research support have fallen, many VA physicians have begun to pursue careers outside the

VA and it has become increasingly difficult for the VA to recruit newly-trained physicians.

I have seen the impact of these changes at the White River Junction VA. The senior colleague who recruited me and who has been my strongest supporter and advocate within our hospital is now discouraged about future funding opportunities within the VA and has shifted his research focus away from the VA. If, as I expect, he withdraws completely from the VA, it will be a major loss to our hospital.

For FY 1991, President Bush has recommended a VA research budget of $198 million, a 7 percent decrease in real dollars below the budget for the current year. The Bush proposal sends a disheartening message to VA physicians about the government's commitment to our research program and its importance to the medical-care program. While the need to reduce the deficit may have been a limiting factor, it did not stop the President from requesting a 36 percent increase for the space station, a 50 percent increase for the superconducting super collider, and an 100 percent increase for the Department of Energy R&D. We do not intend to question the merits of these programs. However, we do question the astonishingly low priority the President has placed on the extremely productive VA research program. This is particularly disconcerting given public support for health research efforts. A national survey conducted at the AFCR's request last year by the Opinion Research Corporation of Princeton, NJ, (see appendix 2) found that when asked to state their No. 1 research objective among five specified goals for science, the greatest proportion (53 percent) said improving health while only 4 percent viewed space exploration and 7 percent cited energy research as their top priority. We hope that Congress will recognize (better than the President appears to) the merits of priority funding for VA research both in response to scientific opportunity and taxpayer sentiment. We urge the members of this committee to take the lead in this regard.

The AFCR supports the Friends of VA Medical Care and Health Research coalition in recommending an FY 1991 VA research budget of $268 million. This recommended budget will restore the program to its 1985 level of effort and allow for a limited number of special initiatives to address health problems that are particularly acute among the veteran population. Of this amount:

—$252.5 million would provide support for 1,849 projects, 26 cooperative studies, and 240 career development awards—roughly the same numbers funded in 1985; and

—$15.5 million would provide support for special research initiatives focused on AIDS, nerve regeneration, geriatric evaluation units, and mental illness.

The AFCR believes that a budget of $268 million is essential if the VA research program is to be restored and stabilized and if the current problems of recruitment and retention at VA hospitals are to be overcome. This 26 percent increase may seem unrealistic in light of current deficit reduction efforts, but we believe that VA research is as worthy of targeted spending growth as the space station and other priority programs. Thank you for the opportunity to express the views of the AFCR.

I would be happy to answer any questions.

APPENDIX 1

POTENTIAL HUMAN BENEFITS AND HEALTH-CARE COST SAVINGS RESULTING FROM VA-SPONSORED RESEARCH

PREVENTION OF CIRCULATORY AND VASCULAR DISEASES

The VA is recognized as a pioneer in the development of antihypertension drugs, a major factor in the significant decrease in mortality rates for heart disease and stroke between 1968 and 1978. During this period, the number of deaths from heart disease per 100,000 Americans decreased by 10 percent (approximately 95,000 lives spared per year); deaths from stroke declined similarly by 25 percent (65,000 lives spared per year).

TREATMENT OF ENLARGEMENT OF THE PROSTATE

A VA-sponsored study of veterans with prostate enlargement suggests that a sizeable number can be treated without surgery. Medical followup costs are approximately $1,000, compared to costs of approximately $6,500 for surgical procedures. Greater use of nonsurgical treatment as recommended by the study can yield the VA savings of approximately $29 million per year and spare many veterans the discomforts and risks of surgery.

DETOXIFICATION TREATMENT FOR ALCOHOLICS

Over 200,00 veterans suffer from alcohol dependence. A VA-sponsored study has determined that for those who require detoxification, outpatient treatment is as effective as inpatient treatment and costs nearly 90 percent less. Increased use of outpatient treatment for the 52,000 veterans provided such therapy each year will yield annual cost savings of approximately $17 million for the VA alone.

GERIATRICS EVALUATION UNITS

Geriatrics evaluation units (GEUs) are designed to improve hospital care for frail, elderly patients. A VA-sponsored study showed that veterans treated in GEUs to have substantially lower mortality rates and fewer discharges to nursing homes compared to those given standard care. Based on these findings, the VA has established 85 geriatric evaluation units across the country. Use of these units should reduce the number of nursing home admissions by 200,000 per year.

APPENDIX 2

Public Opinion Poll Conducted September 9–10, 1989 by Opinion Research Corporation for the American Federation for Clinical Research

Because the Government is limiting spending for its research programs, priorities must be set carefully. It may be necessary to cut funding for some research programs in order to increase funding for others. Would you like to see Government funding increase, decrease, or remain the same for research aimed at:

	Increase		Decrease		Remain same		Don't know	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Exploring space	267	27	256	25	400	40	85	8
Improving health	824	82	23	2	128	13	33	3
Using energy more efficiently	666	66	61	6	230	23	51	5
Improving weapons	206	20	371	37	360	36	71	7
Reducing pollution	761	76	53	5	160	16	34	3

Which one of these research goals would be your top priority?

	Number	Percent
Exploring space	43	4
Improving health	533	53
Using energy more efficiently	69	7
Improving weapons	28	3
Reducing pollution	300	30
Don't know	35	4

PREPARED STATEMENT OF ROY E. PANNELL, NATIONAL VICE PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

My name is Roy Pannell, and I am a National Vice President of the American Federation of Government Employees (AFGE), AFL–CIO. On behalf of the 700,000 Federal employees represented by AFGE, I thank you for this opportunity to testify on the administration's 1991 budget proposals for the Department of Veterans Affairs, and in support of the recommendations contained in the Independent Budget prepared jointly by the Veterans of Foreign Wars, AMVETS, the Disabled American Veterans, and the Paralyzed Veterans of America.

Our union represents 125,000 employees in the Department of Veterans Affairs. Our members are the ones who do the everyday work of providing the services promised through the various veterans' benefits programs. This work includes processing veterans' claims, answering guestions on a wide range of issues, and providing care for those who need medical attention. Most of those who have testified here today are on the receiving end of these services and have felt the pain from inadeguate funding of veterans' benefits programs. Our members feel this pain every day, albeit from the perspective trying to do a huge and enormously important job without adeguate resources to do that job as well as they would like.

The administration's 1991 budget proposes spending $30.9 billion for the Department of Veterans Affairs. While this represents an increase of $961 million over current FY 1990 spending, the reality is that it means a cut worth approximately $700 million below the current services level, according to conservative projections presented in the Independent Budget.

The concept of "current services" has lost its meaning in the two budgets put forth by President Bush, as he has abandoned the practice of measuring increases and decreases in real, i.e., inflation-adjusted, terms. But we should not allow that dubious practice to deter us from using the notion of current services baselines in our discussions. Indeed, we are indebted to the authors of the Independent Budget for providing an honest and realistic picture of the funding needs in the Department of Veterans Affairs, if it is to maintain minimal operating standards based on the last year of full "current services" funding.

The Independent Budget has utilized what it terms a "service delivery model" in order to formulate its projections of funding needs. Instead of calculating current services needs from the perspective of a base eroded through years of inadeguate funding, the Independent Budget used the FY 1988 appropriation as its baseline. From there, the service delivery model projects the real increases in demand for veterans services and benefits based on the actual numbers of veterans who will need services and what those services will actually cost.

AFGE members are concerned that all American veterans receive the full range of benefits and services to which they are entitled. As I mentioned, our members are the direct providers of many of those services. Thus, AFGE is an advocate not only of the veteran, but also of the Federal employees charged with the responsibility of delivering those services. Dramatic changes are needed in the Department of Veterans Affairs in order to allow those services to be provided in sufficient quality and quantity to demonstrate our Nation's gratitude to our veterans, and the respect due to the employees of our Government.

MEDICAL CARE

The crux of the problem in the VA medical care programs—underfunding—is addressed throughout the Independent Budget. One particular passage captures the essence of the problem so well that I would like to quote it here. The problem is defined as follows:

> The Medical Care program is complex and personnel-oriented; more than 60 percent of the Medical Care budget is consumed by personnel costs. If funds are not appropriated to support VA personnel costs, then funds from other discretionary medical care accounts must be utilized. This is the crux of the shortfall problem: For several years, the VA Medical Care program has had to absorb the costs of pay raises, special pay increases and increases in Federal Employees Health Benefits. It also has had to cover the costs of inadequate budgets for new facility activations, and some of the cost of inflation.

In short, the system has been asked to do more with less for so long, it is now in a virtual state of crisis.

The Independent Budget goes on to recount the recent history of how those shortfalls were engineered. In the past several years, when OMB has presented a proposed budget for the VA, it has debited the department 1 percent for an assumed increase in productivity. Productivity increases are of course desirable, but they cannot be assumed into existence. In business, the homily "you've got to spend money to make money" is a widely shared belief. It is based on the fact that business success depends in capturing returns on productivity-enhancing investments. Improvements do not just occur, one has to make certain investments in order to create the potential for those improvements to occur.

But OMB has assumed the occurrence of improvements, in the form of cost saving productivity increases, without ever providing the investments necessary to bring that productivity improvement about. On the contrary, they continually propose taking resources away at the same time as they expect greater amounts of work to be accomplished. Do more with less, the employees of the VA are always told.

At the same time as resources have been reduced, Congress has added benefits to the existing VA health-care entitlement and has expanded the health-care system by adding outpatient clinics, along with several other improvements. Make no mistake, our union applauds Congress' efforts in these areas: the improvements in veterans' benefits are deserved, and constitute sound public health policy. The problem for both veterans and the employees of the DVA is that these expansions in benefits have been implemented within existing appropriations.

In the provision of health care, it is impossible to choose which is more important: equipment or personnel. A patient needing a respirator is not helped if the machine is there but no qualified medical practitioner is there to help the patient use it and to monitor the patient. A patient who cannot breathe without a respirator is not helped if a nurse is there and says I wish I could help you but the VA cannot afford to buy the equipment needed for your illness. Yet these are the kinds of choices the VA is now being forced to make because of inadequate funding.

There is a serious equipment purchase backlog in the VA. There is also obviously a serious shortage of personnel at some VA hospitals. The major reasons why the shortage exists form a vicious circle: First, the VA is underfunded and cannot afford to hire as many health-care providers as it needs; and second, the VA cannot afford to offer pay and benefits comparable to what other health-care providers are offered in the private sector and therefore is unable to attract the personnel it is authorized to hire. These two problems entail a third problem for VA personnel which is that they are expected to carry an ever heavier workload despite inadequate resources to work with and an inferior pay and benefits package. Thus, recruitment and retention problems added to what one might call "planned" or "avoidable" understaffing has created a virtual staffing crisis.

An important point made throughout the Independent Budget is that, at the very least, the VA should be funded in such a way that actual current services may be continued. No gimmicks should be used to define current services, nor should false assumptions about workload be made. Thus, as mentioned above, the Independent Budget defines the genuine baseline as the FY 1988 level, before workload assumptions were changed significantly. The proposed budget for 1991, then, is based on the Independent Budget's own estimate of what the 1990 baseline should be. Again to quote the budget itself: ". . . the largest portion of the recommended medical care budget increase is not for program improvements. It is required, rather to simply preserve a baseline of VA health-care activities and ensure the VA system's ability to provide timely, quality health care to entitled veterans." (emphasis in original)

Inadequate funding may be the most pervasive and most obvious problem plaguing the VA medical system. But there are other serious problems as well, which have been brought to the attention of the members of this committee on several previous occasions. I refer here to the urgent problems created in the appellate court's decision regarding the Colorado Nurses Association.

The court concluded that the VA has no obligation to engage in collective bargaining on the conditions of employment for its Department of Medicine and Surgery employees hired under the provisions of title 38, although the Secretary may choose to bargain. On January 3, 1990, an even more problematic decision was handed down by the same court.

This time the court determined that even if the Secretary exercised his authority to bargain collectively on behalf of title 38 employees, any agreement reached was not enforceable by the FLRA. Taken together, these two decisions mean: First, that unlike any other Federal agency, the VA does not have to bargain over working conditions for all of its employees. Second, when the VA does bargain, the agreements reached are totally unenforceable. The result is blatant, disparate treatment of the title 38 employees at the VA, as compared with the title 5 employees.

I would like, however, to take this opportunity to commend the members of this committee for their leadership and their perseverance in trying to rectify this situation. The 125,000 VA employees AFGE represents appreciate the committee's consistent support in the effort to clarify and restore collective bargaining rights, and negotiated grievance procedures for title 38 professional employees in the VA. Indeed, we are confident that with your help, this matter shall be resolved soon.

To grant these collective bargaining and grievance rights would not only rectify an injustice, it would go a long way toward solving the VA's problems with recruitment and retention of professional medical personnel. Further, allowing full collective bargaining rights over working conditions would do no more than put medical professionals employed by the Federal Government under title 38 on an equal footing with both title 5 employees (who work side-by-side with title 38 employees), and their private sector counterparts, all of whom enjoy the right to engage in collective bargaining and to negotiate fair due process procedures for the settling of grievances.

The peer review boards in the VA, which now serve as both disciplinary boards and tribunals for deciding matters of clinical competence for title 38 employees, are not a reasonable substitute for a negotiated grievance procedure. The humiliation of presenting one's case on a disciplinary matter before what are derisively known among title 38 employees as "kangaroo courts," is an affront to these employees' status as professionals. AFGE seeks to develop a system of due process through collective bargaining whereby an impartial third party is able to address both employer and employee grievances in a manner which is fair to all sides.

Repeated studies of the determinants of job satisfaction on the part of nursing professionals demonstrate that having some semblance of "workplace democracy," or a system which allows employees a degree of control over working conditions is considered a crucial factor in overall job satisfaction. Indeed, this single issue has been shown to be decisive (when other factors are reasonably similar) in medical professionals' choice of employer.

There are several other important matters relating to the issue of equity for certain VA employees to which I hope this committee will lend its support. Currently, registered nurses are the only nursing staff employees in the VA who receive premium pay for work on Saturdays. Nursing assistants, licensed practical nurses (LPN' s), and licensed vocational nurses (LVN's) are all exempt from this benefit. This disparate treatment of medical staff who work side-byside is not only unfair, it lowers the morale of the staff, creates unnecessary tensions among members of a working group, and acts as one more obstacle in the VA's effort to retain and recruit these scarce medical personnel.

Currently, nurses employed by the VA are not permitted to work in their profession outside the VA. This restrictive law has no rationale and is yet another cause of the VA's difficulty in recruitment and retention of qualified medical personnel. Our surveys show that VA nurses strongly want the freedom to work on "off-duty" time for health-care professionals. Around the country, VA nurses are enticed with offers of pay which is sometimes as much as double the rate the VA pays for part-time shift work. Absent substantial pay raises for VA nurses, to deny this freedom to supplement nursing salaries at a time when health-care personnel are in scarce supply throughout the Nation simply makes no sense.

These are among the many legislative changes that do not cost money, but hold the potential for dramatically improving the VA's ability to recruit and retain title 38 employees. I shall only mention a few more of those which we feel are the most pressing. The VA has persisted in its policy of continual shift rotation for nurses at a time when this practice has been largely abandoned in the private sector. In today's increasingly complex world of competing demands from family and work, it is important that employees are able to have some regularity in their schedules. Constant rotation and "doubling-back" of nursing shifts is not a rational practice from the point of view of the veterans (patients) either. It is only natural that the quality of care will suffer when a nurse's shift has been rotated for several days on end. Again, this is a reform that is not costly, but would do much to improve morale, retention, and recruiting in the VA.

VETERANS BENEFITS ADMINISTRATION

Underfunding of VA programs is not ust a matter of cutting back on the benefits provided to our Nation's veterans. Just like the case of medical programs, inadequate funding and the inability to offer pay which is competitive with the private sector has resulted in serious understaffing. VA hospitals suffer continual problems with retention, recruitment, and overwork of existing staff. In the Veterans Benefits Administration, the situation is the same, but the consequences of underfunding have been staggering backlogs in the area of veterans' claims processing. This inefficiency causes undeserved frustration for veterans, undeserved stress for employees of the DVA, and what is more, constitutes inefficiency as it raises the costs of processing on a per claim basis.

Underfunding costs money. At first glance, this seems to be a contradictory assertion, but from the point of view of the VA's mission, it is an unavoidable fact. When work slows down because of inadequate human and material resources, the actual costs of delivering services goes up. Unfilled supervisory staff positions, too few staff, constant turnover, lack of time and personnel for training, all of these are consequences of underfunding, and all of these lower productivity. This is the sense in which underfunding is shortsighted and misguided.

To reiterate, the problems with backlog, bureaucratic inefficiency, and the resultant decline in level of services to veterans are all due to underfunding in the VBA. The underfunding has translated into both understaffing, and failing to provide existing staff with adequate resources to do their jobs as effectively as possible.

Upon examination of the administration's proposed budget for FY 1991, it is clear that the VBA is the relative "loser" in the competition for scarce dollars in the budget of the Department of Veterans Affairs. The President has proposed funding for the VBA at $605.3 million, along with a decrease in full-time equivalent employees (FTEE's) of 266. (The level of FTEE's in the VBA in 1987 was 13,126 or 792 more than is requested for FY 1991 by the President.) The number of FTEE's in the VBA has steadily decreased as the Reagan and now Bush administration sought fewer and fewer FTEE's. The Congress has responded by mandating floors which were higher than the administrations' requests, but nevertheless have constituted decreases from previous years.

It is inescapable that service to veterans will continue to deteriorate as the existing staff is squeezed further, asked to do more with less, and forced to take away from one VBA service in order to provide for another. The President's budget request moves the VBA in exactly the wrong direction. Staffing at the VBA needs to be increased.

The Independent Budget calls for hiring an additional 734 FTEE's in order to address this situation. Note that the authors of the Independent Budget emphasize that this in a minimal number; the additional 734 would only allow services to improve up to the level sufficient to provide the current minimum specified by law. AFGE wholeheartedly supports the hiring of these additional personnel to enable the VBA to provide the services due our Nation's veterans, and to provide more a reasonable workload for the current employees whom we represent.

The Independent Budget recommends deploying these additional 734 workers in the following ways. For answering telephone calls from the estimated 1 million veterans who each year fail to get through because of engaged telephone lines, 195 extra FTEE's should be added to the VBA. It is important to add that new computer and telecommunications equipment are also needed to handle these additional calls.

In the Departments of Pensions, Compensation, and Education, the Independent Budget recommends the hiring of an additional 365 FTEE's. The additional staff are necessary to reduce the enormous backlog in claims processing, and to help establish a new level of service which will prevent such backlogs from developing again.

In Vocational Rehabilitation and Counseling, an additional 69 vocational specialists are recommended to be hired. The Independent Budget notes that the typical caseload for a vocational specialist employed by a State or other Federal programs is 60 cases per specialist. In the VA, the caseload is 135 per specialist, a rate which is 125 percent higher than the recommended 60 per employee.

In the Loan Guaranty program, the Independent Budget recommends hiring an additional 105 FTEE's in order to improve the cure rate on the percentage of loan defaults. Currently, the cure rate is 74 percent the increase in hiring is aimed at improving this rate to 85 percent. These additional hirings would be particularly cost effective for the Government, as it is estimated that each additional FTEE will save the Government $335,000 per year. In addition to saving money in the long run, this move would also help veterans continue homeownership.

The Independent Budget recommends that these 734 be hired immediately in 1990 by means of a FY 1990 supplemental appropriation. According to their calculations, this would entail annualized spending of an additional $25 million, less than $1 for each of the Nation's 27 million veterans. To repeat, these additional employees are needed just to accomplish the existing workload in the VBA in a reasonable manner.

CONCLUSION

The Department of Veterans Affairs should occupy a special place among the Government's spending priorities. The employees who run veterans' programs are committed to demonstrating our Nation's gratitude to veterans for the sacrifices they have made on all of our behalf. Adequate funding for the DVA is absolutely crucial if this goal is to be accomplished.

Mr. Chairman, and members of the committee, I urge you to consider seriously the recommendations contained in the Independent Budget, along with the legislative changes I have described which would improve working conditions and pay for title 38 employees. I thank you again for the opportunity to testify here today and to share AFGE's thoughts on these important issues with you. I would be happy to answer any questions that you and the members of the committee may have.

PREPARED STATEMENT OF SAMUEL J. WALSH, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the committee, The American Legion appreciates the opportunity to set forth its views on the proposed funding for programs and operations of the Department of Veterans Affairs for Fiscal Year 1991 following an initial appraisal of the budget submitted to Congress by the administration.

This budget proposes budget authority of $30.9 billion to fund compensation, pension, education, medical care, and other programs for the Nation's 27.1 million veterans, eligible members of their families, and survivors of deceased veterans.

At the outset, it should be noted that The American Legion recognizes the commendable efforts of the Secretary and Deputy Secretary with respect to their negotiations with the Office of Management and Budget and the President during the development of this budget proposal.

Included in the total is an appropriation request for $30.5 billion, a net amount of $38.8 million associated with certain proposed legislation, and $1.66 billion in permanent authorizations and offsetting receipts. The actual appropriations request for FY 1991 represents an increase of $1.3 billion over the funding level for FY 1990.

On the surface, the proposed funding level for FY 1991 appears to represent a substantial increase over FY 1990. However, upon considering the effect of sequestration under the Gramm-Rudman-Hollings Act on the current budget, and the backlogs in delayed purchases of new and replacement equipment in the medical-care program and National Cemetery System, it appears there will be little real increase in funds to operate the Department of Veterans Affairs. While the budget proposal includes some positive points, there are also a number of what we consider to be ill-considered assumptions and proposals incorporated into the structure of this budget, and in the course of this statement we will address each of these in detail.

Veterans who receive benefits have earned them by virtue of their service and sacrifice—and they deserve them. Veterans are no less interested in the continuing problem of the Federal deficit and the need for fiscal responsibility than any other citizens. In this respect, it is imperative to consider the fact that VA's share of the total Federal budget has continued to shrink in size and is only 2.4 percent for FY 1991. VA has demonstrated a commitment toward fiscal restraint while maintaining a maximum level of service within the authorized resources. A point seldom noted by critics of adequate resources for veterans programs is that if the entire Federal budget had grown at the same rate as VA's, there would be a surplus of funds rather than a burdensome deficit.

If VA is to effectively carry out its mission, it must have funding which is both adequate and stable. Current operations, as well as strategic planning, have been adversely affected as a result of budget cutting initiatives over the past several years. In FY 1990, due to the inability of the Congress and the administration to reach the budget targets of the Gramm-Rudman-Hollings Act, sequestration was imposed across-the-board. Funding cutbacks for the department totaled $180.9 million with a reduction of 2,661 FTEE. As a result, VA's funding level was effectively reduced to that provided in FY 1989.

Prior to undertaking a detailed discussion of those areas of particular concern to The American Legion, we wish to take this opportunity to recognize the efforts of this committee and your leadership Mr. Chairman, in securing a more adequate budget for the Department of Veterans Affairs for FY 1990, than was originally proposed by the administration. This also is applicable to the badly needed supplemental appropriation to the FY 1989 medical-care budget.

With respect to the proposed funding for FY 1991, the Congress will once again be challenged by the continuing shortfalls in personnel and operating funds in the benefit and medical-care programs. Mr. Chairman, we believe it is necessary to reiterate The American Legion's longstanding position on funding of veterans benefits and programs. The American Legion has a total concern for and commitment to the health and well-being of this Nation's veterans dating back to its founding in 1919, and therefore, stands for full funding for veterans programs. By that we mean that there should be provision of such funds as are necessary for VA to effectively carry out each of the programs established by Congress. The American Legion supports all of these programs. Each of them had a purpose when enacted, and we believe each has proven currently to be meeting a legitimate need of the veteran population. While there are certain problems in the operation or administration of some programs, such as the home loan guaranty program, which require correction, we are aware of no programs that at present are superfluous or redundant.

Before proceeding with comment on the specific budget items of the various VA programs, we shall first address a number of the legislative proposals set forth in the budget. These appear to represent a miscellany of ideas, some old and some new, many of which seem to totally ignore the anticipated demand for essential benefits and services.

LEGISLATIVE INITIATIVES

—The Department of Veterans Affairs recommends a cost-of-living adjustment of 3.9 percent effective January 1, 1991. The proposed legislation would index service-connected disability compensation and dependency and indemnity compensation (DIC) benefits to the annual change in the Consumer Price Index (CPI). The position of The American Legion is that these COLAs should be consistent with increases in the CPI. The American Legion, however, opposes that provision which would index compensation changes to the CPI. We have testified in opposition to identical proposals numerous times in the past. Historically, Congress has been fair and generous in providing cost-of-living adjustments. Of equal importance is that hearings before the Veterans' Affairs Committees on proposed legislation relating to COLAs, provides a forum at which other related legislative issues such as special monthly compensation eligibility criteria may be discussed.

—Proposed legislation would revise the criteria for the reduction of pension based on nursing home or domiciliary status. It would increase from 3 to 12 months the period before pension would be reduced. It would also allow up to $10,000 of withholdings to be returned to the veteran upon release from VA care. The American Legion is supportive of this proposal as it would provide needed financial support to the veteran to meet ongoing financial obligations and facilitate reintegration into the community.

—Another proposal would provide access to Internal Revenue Service income information for the purpose of verifying the income of pension beneficiaries. The American Legion would not oppose this proposal on the basis that it will provide the means to more efficiently manage the pension programs. The ongoing problems created by inadvertent overpayments may be solved at least in part by implementing this proposal.

—Proposed legislation would raise from $500 to $1,000 the limit of dental treatment that may be performed on a fee basis by private dentists without the requirement for a second opinion. The American Legion has supported this increase in the past. The proposal recognizes the increased cost of dental services in the private sector and provides more realistic guidelines.

—Another proposal would permit dental treatment on an outpatient basis, rather than on an inpatient basis, to veterans who are scheduled to receive certain hospital treatment and for certain other veterans. The American Legion supports this proposed legislation. It would allow veterans to spend less time in a hospital environment. Further, it would free costly hospital beds for use by patients with more critical health-care needs.

—Proposals would provide outpatient dental care to all World War I veterans, expand eligibility for outpatient dental care for former POWs, and provide oral health care to veterans receiving VA Hospital Based Home Care. We strongly support each of these initiatives. The Legion has been mandated by National Convention resolutions for several years to support the provision of dental care to WWI veterans and to expand the eligibility for such care to former POWs.

—Several legislative proposals refer to increases in salaries for nurses and nurse assistants, and special pay for doctors and dentists. The American Legion is mandated to seek the restructuring of salaries for all positions in the Veterans Health Services and Research Administration. It is a primary objective of the Legion to ensure the provision of high quality health care on a timely basis to eligible veterans who need and seek it. We view with increasing alarm the current developments in the Veterans Health Services and Research Administration which are jeopardizing its ability to provide quality health care to the Nation's veterans due to the inability to attract or retain qualified health-care professionals.

—Another legislative initiative proposes to require veterans without service-connected disabilities, in the middle or higher income categories (category B and C) to make a nominal copayment per outpatient visit and per outpatient prescription and requires a per diem payment for inpatient treatment. It further authorizes recovery from third-party health insurance for the treatment of non-service-connected disabilities of insured service-connected veterans. This proposal is similar to one presented last year. We remain totally opposed to such legislative proposals. This organization is mandated to oppose the means test and any expansion thereof. It is not and never has been shown to be cost-effective. The shortfall in medical-care funding that currently exists has already led to an almost total restriction on treatment for category B and C veterans. The subsequent reduction in workload has been used as the rationale for further inadequate funding levels. We especially oppose its application to service-connected veterans.

The American Legion also continues to oppose third-party reimbursement. However, on the basis of a recommendation of The American Legion's Task Force on Veterans Medical Care in its report of September 4, 1989, we believe that, at a minimum, the expense of collection of third party proceeds to the VA facility generating such funds should be recovered by the facility.

VETERANS BENEFITS ADMINISTRATION

Of the Department of Veterans Affairs total budget of $30,458,963 billion, approximately 53.6 percent or $ 16.3 billion must be allocated to the payment of those statutory entitlement benefits provided under title 38, United States Code. Such benefits include compensation for service related disability and death, non-service-connected disability and death pension, and educational subsistence allowances and benefits. The remainder of VA's annual budget will go toward the operation of the medical-care program, construction, the National Cemetery System, and the general operating expenses account for personnel and administration.

The Veterans Benefits Administration (VBA) is responsible for the administration of the various direct benefit programs and the operation of the 59 VA regional offices located in the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the Philippines. Under the FY 1991 budget, the proposed funding for VBA is $605.3 million. This will support staffing of 12,334 FTEE which is a 266 FTEE decrease from the 1990 level. This decrease in employment is primarily attributable to projected savings associated with short-term modernization initiatives and calls for losses of 15 FTEE in Veterans Services; 5 in Vocational Rehabilitation and Counseling Service; 253 in Support Services. The Compensation, Pension and Insurance Service will have a net increase of 7 FTEE over the FY 1990 level.

Mr. Chairman, The American Legion continues to be supportive of economy of personnel in management, the effective utilization of resources, and maximum productivity by all Federal employees. The mission of the Department of Veterans Affairs as a whole, and the Veterans Benefits Administration in particular, is to provide service to veterans and other claimants and to ensure the timely processing and adjudication of claims for benefits. These activities are necessarily heavily dependent upon the existing automated data processing and computer systems and equipment. They also require a certain number of trained personnel to carry out the day-to-day operations.

As a result of initiatives implemented in FY 1990, together with those proposed for FY 1991, and an increase of 7 FTEE, VBA expects to stem the decline in quality and timeliness in claims processing which has developed over the past several years. Planned actions include: introduction of an automated medical information exchange link between the regional offices and the medical centers, improved decision notices in benefit claims to provide more information to claimants, additional training seminars for VBA personnel, the establishment of the Adjudication Training Academy for management and adjudication personnel, and implementation of a number of ADP and office automation programs.

The American Legion remains deeply concerned about the cumulative effect that consistent and persistent reductions in personnel in the VA regional office has had and continues to have on the claims processing activity at individual field stations. Between 1979 and 1989, the level of employment fell from approximately 6,000 FTEE to 3,759, a decrease of 38.5 percent. During the same period, however, there have not been corresponding decreases in the overall workload. The fact that there are fewer and fewer personnel to do the essential work required has been offset, to some degree, by program changes, increased office automation, and other modernization initiatives. However, the loss of experienced staff, particularly senior adjudication personnel, has directly resulted in increasing processing times for benefit claims and an increased rate of errors in adjudicative actions. Efforts to address these deficiencies have been impacted by recent legislative action and court decisions which necessitate giving more attention and time to improved due process procedures and case development. In our view, quality rather than quantity must be the most important standard in VA operations. However, claimants are still entitled to have their inquiries resolved and claims processed in a timely manner.

Overall timeliness has also been affected by cases which are increasingly complex and that require more man-hours to properly develop and adjudicate. Such cases involve issues relating to the possible long-term health affects of exposure to Agent Orange, disabilities of veterans exposed to ionizing radiation during atmospheric nuclear weapons tests, and the pathology of post-traumatic stress disorder (PTSD), to name a few.

According to VA data covering the past 3 years, the error rate in both rating and authorization actions has continued to increase. Such material and substantive errors involve actions resulting in incorrect benefit payments, the improper granting or denial of benefits, denial of due process, etc. The loss of experienced adjudication personnel has been identified in previous budgets as a key factor in the deterioration in both the quality as well as timeliness in benefit claims processing. Funding was included in the FY 1990 budget for the establishment of an Adjudication Training Academy to train new adjudicators and other VBA personnel. Five hundred thousand dollars has been included in the proposed budget for FY 1991 to provide continued funding to this program. The American Legion is strongly supportive of VA's action to formalize and centralize its training activity for adjudication personnel. We believe this is a necessary and timely step toward reversing the continued decline in productivity, timeliness, and quality in benefit claims processing.

Mr. Chairman, as previously noted, the funding level for VBA is predicated upon declining workloads, enhanced productivity, and service improvements attributable to short-term modernization initiatives. Under the FY 1991 budget, VBA's Twelve Point Plan for modernization has outlined an ambitious schedule of planning, evaluation, and implementation of various initiatives, together with projected personnel savings in certain programs. In our judgment, there remains a critical need for additional staffing support in the regional offices over and above the proposed increase of 7 FTEE. The problems of increasing processing times and deteriorating quality must be directly attacked now, rather than later when modernization has been more fully implemented. We believe the allocation of resources to address these problems can and should be accommodated under the Twelve Point Plan. It is imperative that modernization continue as rapidly as possible with the ultimate goal of improving efficiency and quality in service and claims processing, thereby achieving savings in staffing and resources.

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

It has long been the position of The American Legion that the Department of Veterans Affairs medical-care budget must be maintained at sufficient levels to ensure the provision of high quality patient care to all veterans who apply for such service. This position was recently reaffirmed by delegates to The American Legion's 71st National Convention in Baltimore, MD, who approved resolution No. 4, which mandates this organization to urge the Congress and the President to provide sufficient health-care funding for veterans. This resolution calls attention to the reality that insufficient appropriations and outlays for the Department of Veterans Affairs recommended by the Office of Management and Budget may be effected only by cutting service to eligible veterans in the areas associated with medical care.

Resolution No. 4 also expresses the Legion's belief that the medical benefits provided by law to veterans are in fulfillment of a sacred obligation of the Nation to its defenders. Congress is therefore, urged to assign the highest budgetary priority to the provision of funds for the administration and delivery of veterans medical-care benefits.

Mr. Chairman, several years of decremental funding have led to critical budgetary problems Department-wide especially in the medical-care system. We have witnessed over the past two fiscal years medical centers consolidating internal operations and severely curtailing inpatient and outpatient services to what are considered to be discretionary veterans (category B and category C) and even to non-service-connected category A veterans. One year ago, we testified that it would be difficult to reverse the rationing of health-care services once the process had begun, and 1 year later we do not see the situation improving. In the current fiscal year our field service representatives have visited roughly 15 medical centers and all of those facilities have reported a more dismal fiscal picture during this fiscal year than the preceding one. Medical centers are being forced to reduce the number of health care and support personnel to simply remain fiscally solvent through the end of the current budget year. VA reports new and replacement equipment backlogs are in excess of $600 million. Health-care services for the discretionary workload are virtually nonexistent except in emergency cases. Medication eligibility has been drastically reduced, and in many instances poor and uninsured veterans cannot afford to privately purchase prescriptions and over-the-counter medications. Veterans refused care are not always fortunate enough to receive alternative health-care services in the private sector due to a myriad of factors. The American Legion finds it difficult to believe that it is the intent of Congress that veterans who are not determined to be category A mandatory care patients are to be administratively disposed of and not receive necessary health care. This is now occurring.

This phenomena applies to all veterans but especially to older and poorer veterans who have always believed the Department of Veterans Affairs would be available to them if and when they needed its services or were retired and unable to retain or obtain private health-insurance coverage. Many veterans today, due to age and deteriorating health conditions, cannot obtain private insurance coverage at all. Many times if they do it is only by paying extremely high premiums. These individuals have been falling through the health-care safety net with nowhere to turn. We believe, Mr. Chairman, that the individual social conditions of veterans need to be considered prior to closing the hospital door in their time of need.

The American Legion has and will continue to oppose the means test program. Aside from the means test being more costly to administer than profitable to the U.S. Treasury, we believe this program does not adequately identify who the most needy veterans truly are. Elderly veterans with fixed incomes, which may be barely above the various means test category thresholds, are no better off financially in the event of major illness. When the means test became law it was the stated view of VA that so long as category B/C veterans agreed to making the required copayment, VA medical care would be provided. The American Legion then was concerned that the means test could very easily lead to the elimination of thousands of eligible veterans from VA rolls. Mr. Chairman, that is the case today.

We receive many letters from veterans and their spouses attesting to the fact that by being refused VA health care they have incurred severe economic hardship. There has to be a more benevolent and fair manner by which to determine who the most needy veterans are compared to the current application of an income or net worth test.

Beginning in FY 1989 and continuing into FY 1990 VA has managed its resources by restricting access to health care for discretionary care veterans and by reallocating funds between accounts. Consistently, employment levels have undergone significant reductions to enable individual medical centers to meet other cost obligations. Hospital beds and wards have been closed, pharmaceutical eligibility has been curtailed, medical-care programs have been consolidated and/or reduced, and a major reorganization of VHS&RA field offices is underway. All the while, the unique health-care requirements of the veteran population continue to grow. The needs of the aging veteran population require special attention. The recruitment and retention of Federal health-care personnel provides special challenges. VA must be able to plan for and deliver the necessary milieu of health-care programs. In short, we believe the VA medical-care budget must be needs based, rather than deficit driven.

The FY 1991 medical-care budget proposes an increase of $901.3 million above the current year budget request. The total VA health-care budget for FY 1991 would stand at $12.3 billion and the employment level would be set at 194,138.

Mr. Chairman, we believe the administration's budget proposal for VA medical care is a positive step toward meeting the needs of the Nation's largest independent health-care system. We witnessed an increase in the FY 1990 VA medical-care appropriation prior to Gramm-Rudman-Hollings reductions, and the proposed level for FY 1991 will help to further close the gap between those resources which are truly needed to maintain a high level of quality care in the VA health-care system versus the number of patients seeking care. We believe that steady increases in the VA medical-care account over future years will definitely be required to improve the level and quality of services provided.

Although the proposed FY 1991 budget reflects an increase of $901.3 million over the current year spending level, we must point out that sequestration for FY 1990 under Public Law 99-177 amounted to $158.4 million, and an additional $94 million was reduced from the FY 1990 funding level as a result of a VA error in computing its current year personnel costs. These funding shortages in FY 1990 amounted to $252.4 million which, we believe, must be offset against the proposed FY 1991 funding increase. Add to that a current year medical equipment backlog of over $600 million and it can be clearly seen that the proposed FY 1991 funding increase will only permit VA to uniformly meet its existing requirements. We cannot become complacent believing the proposed FY 1991 medical-care budget will permit VHS&RA to meet all of its budgetary requirements. Rather, the proposed FY 1991 budget will allow VA to recover some lost ground from previous year decremental budgets.

Mr. Chairman, The American Legion does view positively the level of medical-care funding proposed in the administration's FY 1991 budget submittal. We believe the increase will help to prevent further slippage in the delivery of medicalcare services. We must, however, point out that the problem of access to care for the discretionary workload veterans may not be significantly improved without a commitment from VA officials to direct a portion of FY 1991 resources toward creating a more equitable eligibility policy. As previously commented, not all category B or category C veterans have the means to obtain alternate health-care services. We believe VA must provide care to those veterans who would otherwise incur severe economic or social hardship as a result of being refused VA health-care services.

We note a proposed increase of 2,837 health-care personnel for FY 1991. Of this total 2,098 personnel are targeted for new facility activations. VA currently lags behind in facility activations due to funding shortages over the past 2 fiscal years. This proposal is necessary and we anticipate it will permit VA to recover some lost ground.

As reported, there is a current new and replacement equipment backlog in excess of $600 million. The FY 1991 budget proposal recommends $272.5 million for new equipment purchases and $113.2 million for replacement equipment. A total of $215 million of this is to be directed toward facility activations, leaving roughly $149 million available for existing facilities and for education and training activities. At the current rate of acquisition, the equipment requirements of VA will continue to be deficient.

On the positive side, VA is proposing funding and personnel increases for extended-care programs of $27.4 million and 428 FTEE. Other proposed program increases include drug and alcohol treatment, compensated work therapy, quality assurance, unit dose, contract hospitalization, trainee stipends and salaries, and education and training activities. Other program expansions proposed include AIDS treatment and research, beneficiary travel, assistance to homeless veterans, VA/DoD sharing activities, State veteran home rate increases, and health-care employee special salary rates. All of these recommendations are positive and necessary.

We believe continued emphasis is required to ensure that planned activation of community-based and outreach clinics under the MEDIPP process is accomplished in a timely manner. However, activations are provided no direct funding support in the proposed FY 1991 budget. Also, we believe continued emphasis is required to ensure that post-traumatic stress disorder (PTSD) is treated in a timely manner, close to a veteran's primary residence. No mention is made of the amount of funding directed to PTSD care in the FY 1991 budget submission.

The proposed FY 1991 medical-care budget will enable VA to address some longstanding programmatic requirements. We also know that many medical centers are being forced to curtail treatment services and reduce discretionary workloads in the current year budget. Before any real improvements are made in the VA medical-care system a good amount of "catch-up" is necessary. The FY 1991 budget proposal will enable this process to begin, but it must not be viewed as a complete remedy.

MEDICAL AND PROSTHETIC RESEARCH

The Department of Veterans Affairs Medical and Prosthetic Research Program is a matter of particular interest to The American Legion, as a result of our sensitivity to the importance of research in the triad of VA health-care programs: clinical care, education of health manpower, and research. These three functions cannot thrive independently—the presence of the other two is required. It would be impossible for VA to continue to provide high quality medical care without a strongly funded research program. As this committee knows, much of the research in which VA engages is applied research which is advantageous not only to the mission of VA, but is of direct benefit to all mankind. Equally as important is the premise that a strong research program ensures the recruitment and retention of high quality physicians into VA service. We believe the Federal government could make no wiser an investment than ensuring a vigorous and viable VA research program.

The FY 1991 Medical and Prosthetic Research funding request represents a decrease of over $14.1 million and a reduction of 421 FTEE from the 1990 current estimate. The entire funding and personnel reduction is targeted in the area of medical research. Both Rehabilitation Research and Health Services Research functions will gain modest increases of $1.139 million and $1.021 million, respectively.

The following is a summary of the FY 1991 Medical and Prosthetic Research funding request:

MEDICAL RESEARCH

Efforts in this area fall into two broad categories: research on medical, dental and psychiatric problems that are specific to the veteran population, and research on general health problems that are particularly prevalent among veterans (e.g., alcoholism, aging, and schizophrenia). Most of the investigators are VA clinicians and the close links between the research and patient-care functions give the medical research program and patient care functions a clinical orientation that is directly related to the goal of providing state-of-the-art, quality medical care to the veteran patient. The core of the program involves investigator-initiated studies which closely link cooperative studies and career development initiatives. Project funding for these studies is based on scientific merit.

The budget authority requested for medical research in FY 1991 provides for an appropriation level of $165.5 million and 3,483 FTEE, a decrease of $16.3 million and 355 FTEE, exclusive of the one-time 1990 congressional adjustment; a decrease of $5 million in reimbursable programs, and a one time reimbursement in 1990 of $20 million from the Department of Defense. In FY 1991 the net obligation level for medical research will decrease $29.7 million below the FY 1990 level and average employment will decrease by 440 FTEE. Not described in the budget proposal is an estimated $4.5 million increase which would be necessary above the current year funding level to adjust for inflation and the 1990 annualized pay increase. This offset would bring the net reduction for medical research activities in FY 1991 to roughly $35 million.

The amount of reduction cannot be compensated for by realigning priorities within investigator-initiated studies. These studies account for the largest program reduction for FY 1991 (minus $14.6 million). Any National Institutes of Health (NIH), other reimbursable grants, or Department of Defense support cannot be projected with certainty. If VA clinical investigators cannot be assured of budgetary stability from year to year they may have no other alternative but to leave VA service.

The American Legion is concerned by the decrease in the medical research budget for FY 1991 and strongly recommends that Congress provide an adequate level of funding and personnel for medical research activities in FY 1991.

REHABILITATION RESEARCH

This program focuses directly on the needs of the veteran who is functionally impaired as a result of amputation, paralysis or the loss or impairment of his or her vision, hearing or speech. The latest computer and other technological advances are used to develop devices, techniques and concepts in rehabilitation that will minimize the disability and promote functional independence among veterans.

The FY 1991 budget request for rehabilitation research activities is set at $22.8 million with 278 supportable FTEE. This request represents an increase of over $1.1 million above the 1990 appropriation level with no increase in FTEE. During FY 1991, the rehabilitation research and development program will continue work on approximately 150 projects.

The American Legion supports this budget request which should provide continuity and stability within the program.

HEALTH SERVICES RESEARCH

The goal of this research is to improve the effectiveness and efficiency of the Department of Veterans Affairs health-care delivery system. Health-services researchers develop and disseminate information designed to help clinicians, investigators and administrators select medical interventions and administrative actions that are most appropriate to the department's mission, which is the provision of quality medical-care services to the veteran patient.

The FY 1991 budget request for health services research activities will provide $10.3 million and 215 FTEE which provides for a funding increase of roughly $1 million and 19 additional FTEE. This appropriation will allow the service to continue its current level of ongoing projects and investigator-initiated research. We are extremely supportive of this service's proposed budget request.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The grant program assists the States in acquiring or constructing State home facilities for the furnishing of domiciliary, nursing home, or hospital care to veterans. Legislation has been enacted extending the program's authorization through September 30, 1992.

Based upon the priority list of applications pending approval, the FY 1991 appropriation request of $42 million should provide for 16 projects which will produce 809 nursing home beds and 250 domiciliary beds.

The American Legion considers this program a wise investment. Services provided by State homes substantially reduces the funding burden that would otherwise be borne by VA. As we move into a period of a rapidly aging veteran population, the States can be of major assistance to the Federal Government in the care of the aging veteran population through State extended care facilities. In order to materially ease the fiscal pressure on VA, adequate funding must continue to be made available to the States so that the program grows commensurate with the demand for service.

GRANTS TO THE REPUBLIC OF THE PHILIPPINES

The budget proposal provides for a grant of $484,000 to the Veterans Memorial Hospital in Manila to replace and upgrade equipment and to rehabilitate the physical plant and facilities. This grant has been made by the United States consistently since the end of World War II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during World War II. The American Legion believes there is continuing obligation by this Nation to assure the availability of care and treatment for these veterans and we endorse this grant.

CONSTRUCTION PROGRAMS

The FY 1991 budget proposal reflects an overall request of $694.5 million. This amount is subdivided as follows:

Major construction—$530 million
Minor construction—$145.6 million
Parking Garage Revolving Fund—$18.9 million
Nursing Home Revolving Fund—$73,000

The overall FY 1991 construction budget request represents an increase of $164.5 million over the FY 1990 current budget estimate. This figure amounts to a 30 percent increase over 1990 funding levels for all construction activity.

It is obvious Mr. Chairman, that the proposed level of construction funding for FY 1991 is a marked improvement over recent years, particularly in the major project account. We have some reservations concerning the current backlog of minor construction projects which currently total $150 million. We will offer our appraisal of the FY 1991 construction funding proposal by individual account.

MAJOR CONSTRUCTION

The FY 1991 funding request of $530 million represents an increase of $121.5 million over the current year budget estimate. We believe the proposed budget will make it possible to initiate a number of significant construction projects, and complete some others.

We are unaware if any major construction projects were recommended but not approved for FY 1991 funding, in addition to the list of selected projects. It continues to be a longstanding priority of The American Legion that the capital plant of the Department of Veterans Affairs must be adequately maintained. This objective can be accomplished by maintaining a needs based medical construction budget. We do not believe this objective can be realized without continuing commitment and support by the administration and the Congress. The level of funding proposed in the account for FY 1991, we believe, represents a fair endorsement of this concept.

It should be pointed out that two projects account for $319.5 million of the total major construction request. This figure represents 60 percent of the $530 million proposed. These projects are: Detroit, MI—replacement and modernization ($240.1 million); and Indianapolis, IN—clinical improvements and Mental Health Behavioral Science Center ($79.4 million). Another important project is a 120-bed nursing home care unit at West Palm Beach, FL ($10.2 million).

We feel it important to emphasize that once a project is completed and turned over to the Veterans Health Services and Research Administration (VHS&RA), this discharge in itself does not guarantee full facility activation. During FY 1989, of 94 planned activations, only 45 were fully activated. With respect to those which were not activated or were only partially activated, the main reasons cited for their status were that the project was still under construction, the construction award was delayed, or additional activation funds were required.

MINOR CONSTRUCTION

The FY 1991 funding request of $145.6 million represents an increase of $52.7 million over the current year budget estimate. The FY 1990 minor construction budget estimate of $114.7 million was subsequently reduced $1.8 million pursuant to Public

Law 101-144 and $19 million based upon appropriation language leaving an actual budget estimate of $92.9 million. The FY 1991 budget estimate will enable the Office of Facilities to recoup $20.8 million from the previous year appropriation level.

Currently, the backlog in minor construction projects totals approximately $150 million. The FY 1991 budget request will certainly help reduce backlogged projects, but will not permit the department to progress to any great extent. Several years of sustained, strong minor construction funding is required.

It is noted with concern that of the total appropriation requested for FY 1991 ($145.6 million), an amount of $44.5 million is included for personnel and other expenses of the Office of Facilities, thereby effectively reducing the funding amount for actual construction projects.

As a critical need exists for current and future VA nursing home care beds only $1.5 million in FY 1991 minor construction funds is targeted for the conversion of existing hospital beds to nursing care beds, and the renovation of current nursing care wards to meet VA space criteria standards. We believe the conversion and renovation of current nursing care beds is a cost-effective approach to meeting additional VA nursing care demands. Mr. Chairman, we trust this committee will review this subject, particularly in light of the fact that the original FY 1990 request of $2 million for the same purpose was removed and grouped into a general improvements category.

Since a listing of specific minor construction projects currently prioritized for funding is unavailable, we can only anticipate that mandatory backlogged projects should receive the highest priority.

PARKING GARAGE REVOLVING FUND

The Parking Garage Revolving Fund provides for constructing, altering, and acquiring parking structures in order to accommodate the vehicles of employees of medical facilities, vehicles used to transport veterans and eligible persons to and from such facilities for the purpose of examination or treatment, and the vehicles of visitors and other individuals having business at such facilities. The collection of parking fees is required at each medical facility where funds from the revolving fund are expended for (a) a garage constructed or acquired by the Department of Veterans Affairs at a cost exceeding $500,000 (or, in the case of acquisition by lease, $100,000 per year); or (b) a project for the alteration of a garage at cost exceeding $500,000. In addition, the Secretary at his discretion may establish fees at other VA hospital facilities.

An appropriation of $18.9 million is requested for FY 1991 to be financed with new budget authority in the major construction appropriation. Parking facilities to be constructed under the FY 1991 appropriation request include facilities at Gainesville, FL ($12.3 million), and Indianapolis, IN ($6.6 million).

Mr. Chairman, through site visits to VA medical facilities by our Field Service representatives we can attest that many VA facilities require special parking construction consideration. Due to the limited funds available through the Parking Garage Revolving Fund only several projects per year can be accommodated.

We are certainly supportive of this program and future parking garage construction projects must continue to be prioritized on a greatest needs basis.

NURSING HOME REVOLVING FUND

The Nursing Home Revolving Fund provides for construction, alteration, and acquisition (including site acquisition) of nursing home facilities and may be used only as provided for in Appropriation Acts. Receipts to the fund shall be realized from the transfer of any interest in real property that is owned by the United States and administered by the Department of Veterans Affairs and that has an estimated value in excess of $50,000. Amounts realized from a transfer shall be administered as a revolving fund and shall be available without fiscal year limitation.

Beginning in FY 1991 this revolving fund will realize receipts of $73,000.

NATIONAL CEMETERY SYSTEM

The FY 1991 budget proposal of $54.8 million represents a net increase of $6.5 million and 52 FTEE over the FY 1990 current estimate level.

This increase is intended to provide for increasing workloads at existing cemeteries, maintenance and equipment replacement, activation of the San Joaquin Valley National Cemetery, additional FTEE and associated salary and benefit funding.

The current budget estimate for FY 1990 is $48.3 million and 1,224 FTEE. This represents a net reduction of $509 million and 14 FTEE from the levels requested in the original FY 1990 budget. The areas most severely affected were: rents, communications and utilities ($205,000); other services which include maintenance of equipment, buildings and grounds ($418,000); and equipment replacement ($849,000). These reductions followed several years of restricted operating budgets within the National Cemetery System resulting in diminished ability to maintain buildings, grounds and machinery and a $5.6 million backlog in replacement of needed equipment.

The proposed budget for FY 1991 allows only $2.2 million for replacement of backlogged equipment. The National Cemetery System projects that $2.5 million will be needed to replace equipment which will come due for scheduled replacement in FY 1991 alone. NCS reports that 37 percent of all essential equipment has been extended approximately 6 years beyond its normal replacement date. Much of this equipment is no longer economical to operate or maintain. This has led to unanticipated and excessive personnel use in order to continue operations and to maintain cemetery appearance.

Past year budgets have not been adequate to keep pace with rising operating expenses. This has seriously affected NCS's ability to maintain its traditional high standards of appearance and service. Legislated salary increases, rising costs of material, utilities, contracts and other areas have of necessity received priority funding which often left insufficient moneys for needed maintenance and equipment.

Public Law 99-576 in 1986 directed the NCS to conduct a study of its future burial space requirements. That study reported, as of 1987, only 65 cemeteries were receiving new interments. By the year 2020, more than half of these will be closed to new burials. The report also included a list of 10 key locations in which cemeteries will be needed to meet future demands of the system. To date, only one of these locations (San Joaquin Valley) has been funded for development. We believe this situation prevents the NCS from developing timely and responsive plans to meet the projected interment requirements of our Nation's veterans.

The mission of the National Cemetery System is to provide, in perpetuity, a dignified burial and resting place to those who unselfishly served their Nation in time of need. The FY 1991 proposed budget does not allow that requirement to be met in our judgment. We strongly believe that adequate funding should be provided to ensure that the National Cemetery System can maintain its facilities in an appropriate manner and deliver the benefits and services mandated by law.

VA HOME LOAN PROGRAM

As this committee is aware, the Home Loan Guaranty program operated by the Veterans Benefits Administration has served more than 13 million veterans since its inception in 1944 by providing government guarantees in lieu of a downpayment to qualified veterans. In recent years, the Congress has been forced to appropriate funds to insure the solvency of this program.

Public Law 101-237 created the Guaranty and Indemnity Fund to finance all operations of the program for loans closed on or after January 1, 1990 except for loans made on manufactured homes. The American Legion views passage of this legislation as an important milestone in the evolution of this benefit.

Apparently the administration does not take a similar view since several legislative proposals have been made. The most onerous of these would require the veteran to make a 4 percent downpayment on any loan over $25,000 with the first $25,000 being exempt. While this requirement would give the veteran an immediate "stake" in the investment and thereby perhaps reduce the chances of some future foreclosure, the proposal only makes sense if the default rate is abnormally high. We suggest that the overall foreclosure rate of 5.04 percent for VA guaranteed loans is not high enough to justify the erosion of a benefit earned by honorable service in the Armed Forces of the United States.

We recognize that there are regional problems with VA guaranteed loans, as well as particular problems with certain populations of VA borrowers. We suggest that most of these problems could be alleviated through the application of underwriting standards which are more stringent. It is patently unfair to charge all veterans a 4 percent downpayment when a relatively small proportion of VA loans are a problem.

The Guaranty and Indemnity Fund is funded by a fee paid concurrently by the veteran borrower and the Government with the veteran contributing 1.25 percent of the loan as a fee and the Government contributing .75 percent over a 3-year period.

Another administration measure is that a "funding fee" of 1.75 percent be levied on the veteran borrower. No indication of where this fee would be deposited is made in the proposal. We can only assume that, as was the case previous to the passage of

Public Law 101-237, it would go into the general revenue of the U.S. Treasury. This is unacceptable. The American Legion accepted the fee arrangements in Public Law 101-237 only because the Indemnity Fund was created as "insurance" against future financial liability to the veteran. To require a fee to be paid with no benefit accruing as a result of the payment of the fee is patently unfair.

The administration also proposes to change the regulations governing the acquisition of property on defaulted loans to provide for the inclusion of the losses incurred on resale of property in the calculations. As we understand the current process, the holder of the defaulted loan has the option to convey the property to VA only if the "net value" of the property exceeds the total indebtedness minus the amount of the guarantee, or if a larger bid was made for the property as a minimum amount permitted under State law. Net value was defined as the fair market value minus the cost of acquiring and disposing of the property including taxes, maintenance and resale expenses. Adding the cost of losses incurred to this calculation only lowers the net value of the property, making the veteran liable for payment of additional moneys should VA not be able to sell the property at a price above what the veteran owes on the loan. This is not acceptable to The American Legion. In most cases when a veteran loses his home, he loses everything; it is extremely unlikely that VA will ever be able to collect.

We note that the Department of Veterans Affairs is studying changes to 38 CFR 36.4323(e) "to allow for release or partial release of a debt prior to foreclosure," applicable where the loan default is not due to fraud, misrepresentation or bad faith, and where the default is beyond the control of the veteran obligor. We applaud this effort. It will cure a longstanding inequity pointed out to the Subcommittee on Housing and Memorial Affairs last year. We look forward to the opportunity to comment on the proposed amendments when published.

DEPARTMENT OF LABOR PROGRAM BUDGET

As a matter of information, The American Legion has some major concerns with the budget request for the Veterans' Employment and Training Service, operated by the Department of Labor. While the administrative portion of the budget appears to be adequate, the grants portion, which is funded out of the Federal Unemployment Tax Authority (FUTA), is not enough to maintain the staffing requirements mandated by Public Law 100-323. Only 1,730 DVOPs, out of the 1,883 necessary, are funded with a budget request of $74.47 million. The number of Local Veterans' Employment Representatives is mandated by law at 1,600, yet the budget request of $68.6 million funds only 1,465. This shortage of 153 DVOPs and 135 LVERs amounts to a severe reduction of manpower in the face of a demonstrated need for the type of services they provide. We would urge support from this committee to fund fully the grants portion of the Veterans' Employment and Training Service at a level of $15.2 million to meet the requirements of the law.

Mr. Chairman and members of the committee, the Assistant Secretary of Labor for Veterans' Employment and Training, recently signed a contract with the University of Colorado at Denver to operate the National Veterans' Training Institute. The amount of the contract was $8.7 million or $2.9 million per year. The budget request contains only $829,000 to fund NVTI for 1 year. This will force Assistant Secretary Collins to use a major portion of his discretionary funding to ensure the proper operation of NVTI. Further, as funding levels are reduced, participation rates drop and economies of scale are lost. In FY 1989, LVERs and DVOPs were trained at a cost of $1,472 per student. The 1990 request will raise that cost to over $2,000 per student. This makes no fiscal sense and we ask your support in funding NVTI to the $2.9 million level.

The American Legion continues to be concerned about the precarious nature of "employment tools" used by DVOPs and LVERs: the Veterans' Job Training Act (VJTA) and the Targeted Jobs Tax Credit (TJTC) and Title IV C of JTPA. Although Public Law 100-323 extended VJTA for 2 years, the FY 1989 and FY 1990 VA budgets failed to fund this program, which was tailor-made for Vietnam Era and Korean War veterans. Likewise, the FY 1991 budget ignores the program. Since its inception, over 22,000 veterans have successfully completed training and are now employed in meaningful jobs. They are now taxpayers; assets rather than liabilities to their communities.

Although TJTC does not fall under the jurisdiction of this committee, it is another program used by DVOPs and LVERs to get veterans off welfare rolls and onto payrolls. The first session of the 101st Congress gave TJTC a 1-year extension. Vietnam Era veterans are only one of the groups specifically targeted by TJTC. Over 35,000 veterans have re-entered the work force thanks to TJTC. We would ask this committee to help us persuade the Ways and Means Committee to make TJTC a permanent "employment tool." TJTC provides a small tax incentive for employers to hire those citizens identified as economically disadvantaged.

Much was said during the election campaign about the Job Training Partnership Act (JTPA) and its impact on helping Americans get good jobs. Each year, the amount of funds allocated to Title IV C for veterans has remained disproportionately low. We would ask this committee to help us seek favorable action by the Committee on Education and Labor to increase Title IV C dollars.

CONCLUSION

Mr. Chairman, in this statement we have set forth the earnest opinions and positions of The American Legion on a variety of subjects that are included in the administration's budget proposal for FY 1991 which we consider to be of special importance to the Nation's veterans. We have addressed those programs we believe to be of highest priority in a department whose activities are all of high priority, because they are intended to meet the needs, first of those who were disabled in service, then the reasonable needs of all those who have served honorably when called to do so by this Nation.

The proposed Department of Veterans Affairs budget for FY 1991 reflects an increase over the funding level for the current fiscal year, for which we are grateful. However, it also contains some significant challenges.

For some unexplained reason, insufficient attention is being focused on the impact that consistent and persistent staffing reductions in the Veterans Benefits Administration is having on the quality and timeliness of the delivery of benefits and services to veterans. Amid lawsuits, complaints by veterans and service organizations, figures reflecting a deterioration in timeliness and a myriad of other negative factors, the Office of Management and Budget continues to chip away at the employment level of VBA. We are constantly told enhanced automation will alleviate the deteriorating timeliness concerns, however, these assurances have yet to be realized.

We believe it is necessary to comment again this year on the continuing cutbacks being experienced in the quantity and timeliness of medical care provided America's veterans. The amount of additional medical-care funding proposed for FY 1991 will only prevent further slippage in the delivery of health-care benefits. VA has a great deal of lost ground to recover before any actual substantial health-care delivery improvements will be forthcoming.

We are especially concerned about the workload cutbacks with respect to category B and C veterans. In order to maintain acceptable quality of care standards, VA has been forced to eliminate thousands of eligible veterans from its rolls. The American Legion has found that many of these veterans are unable to find or afford alternative care. The longstanding mission of the Department of Veterans Affairs to provide quality clinical care, education of health manpower, and research is fundamentally being challenged in all areas.

The American Legion appreciates this opportunity to present its views on the FY 1991 budget based on a preliminary analysis, and we trust that this committee will examine and consider the problem areas we have identified. We have commented specifically on those areas which we feel present the most glaring problems, and we have responsibly addressed each of the legislative initiatives with respect to the concerns of The American Legion. No doubt, we will be sharing additional thoughts with the committee as the budget process moves forward during the next several months.

Mr. Chairman, comment has been requested on two legislative measures relating to proposed reorganization within certain operating programs of the Department of Veterans Affairs.

S. 2101 would waive the waiting period requirement of title 38, United States Code, 210(b)(2), for a planned administrative reorganization of the loan guaranty division at the Togus VA Medical and Regional Office Center. Under the planned reorganization, the loan guaranty division at Togus would be closed and all loan guaranty operations would be transferred to the loan guaranty division of the Manchester VA regional office.

Prior to the implementation of this type of administrative reorganization in any fiscal year, the Secretary of Veterans Affairs is required by section 210(b)(2) to submit a report to the appropriate congressional committees containing a detailed plan and justification for any such reorganization. That report is to be submitted not later than the day on which the President submits the budget for the fiscal year to Congress.

The reorganization affecting loan guaranty activities at Togus is part of a plan to create a consolidated New England loan guaranty division located at the Manchester VA regional office which would include the loan guaranty divisions from the Boston and Hartford VA regional offices. This is to provide centralized operations for construction and evaluation, loan processing, loan service and claims, and property management. The functional reorganization is expected to provide improved timeliness and service to veterans and other beneficiaries and better servicing of guaranteed loans and management of foreclosed properties. Veterans Services Divisions at each of the affected regional offices will continue to issue Certificates of Eligibility to veterans within their respective service areas. All other loan guaranty activities including the issuance of certificates of reasonable value, processing of loan applications, issuance of guaranty, servicing of defaulted loans, payment of claims under guaranty, and acquisition and disposition of foreclosed properties will be handled by the New England loan guaranty division at the Manchester VA regional office.

The American Legion is concerned by any proposal by the Department of Veterans Affairs to reorganize or consolidate field office functions that may jeopardize or otherwise adversely affect veterans' access to benefit information and assistance or claims processing activities. The delegates to the 1988 national convention approved resolution No. 128 opposing any VA proposal to centralize or reassign veterans' claims processing activities. Although basic loan guaranty service would be maintained at each of the VA regional offices through Veterans Services, veterans and others who request a personal hearing on a claim involving loan guaranty benefits would be required to travel to Manchester where all such hearings are to be conducted. We believe this will pose a severe and unnecessary burden to many who wish to have their cases heard. Currently, this type of hearing is conducted by loan guaranty personnel at their local regional office. We believe there is a legitimate need to ensure the continued availability of personal hearings within each regional office. The American Legion therefore, does not support the current plan for reorganization and consolidation of loan guaranty operations and service for the New England States.

Mr. Chairman, with respect to S. 2103, this measure would waive the reporting and waiting period requirements of section 210(b)(2) of title 38, United States Code, for a planned administrative reorganization of the regional field offices of the Veterans Health Services and Research Administration (VHS&RA).

The stated purpose of this reorganization is to conserve fiscal resources through the elimination of program redundancies and improve efficiency by strengthening the span of control over hospital operations. The American Legion at its 1989 national convention approved resolution No. 359 urging that steps be taken to strengthen communication lines between the field offices of the medical regions and Central Office in Washington, DC. While The American Legion would not oppose the relocation and consolidation of existing medical regional offices, nor the elimination of existing medical district offices, as proposed, we do have a number of concerns with respect to the timeframe of the regional office reorganization.

The first phase of the planned reorganization involves the closure of the 27 medical district offices beginning on March 31, 1990. The second and last phase calls for the consolidation of the number of medical regional offices from seven to four. We believe there are a number of personnel and programmatic considerations that must be satisfactorily addressed and resolved prior to the implementation of the reorganization plan. These relate to the effect of any such major reorganization on ensuring effective quality assurance and MEDIPRO programs, improving access to care for discretionary workload veterans, and maintaining the grassroots MEDIPP program concept.

In regards to the reduction of the current seven medical regions to four, we believe this proposal is realistic and attainable but should not be conducted in a precipitous manner. In order for VA to move forward with the phasing out of the medical district offices and reassigning some district office staff to the four medical offices, it will be necessary for VA to receive congressional approval of the medical regional office reorganization plan. We believe once the reorganization plan is approved by Congress, several months will be required to systematically complete the reorganization process.

Mr. Chairman, it is our understanding that the resource savings attributable to the proposed reorganization will be allocated to direct patient care services. With this caveat in mind, and the concerns expressed previously regarding the transfer of current medical district functions to the four medical regional offices, we are supportive of the VHS&RA reorganization proposal and would not oppose the waiver provision of S. 2103.

Mr. Chairman, that concludes our statement.

PREPARED STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. Chairman and members of the committee, the Vietnam Veterans of America, Inc. (VVA) appreciates the opportunity to present its views on the budget for the 1991 fiscal year. Generally, in consideration of previous VVA submissions of testimony on the VA budget in the last 3 years, certain issues affecting veterans persist. All of the veteran service organizations as well as other concerned groups of American citizens have in the last 3 years continued to note serious issues relative to the ability of the Department of Veterans Affairs (VA) to effectively carry out its mission.

All indications are that the VA, as in the last few years, will continue to experience a widening gap between dollars needed to carry out authorized programs and the level and quality of programs needed to barely maintain the system. Salaries will continue to go up, the technology to deliver health care will continue to expand, associated costs will continue to rise, and the acuity index, as all veterans get older, will each persist in driving up costs. Added to this is the inability of the VA to produce effective long-range strategic plans, especially in terms of potential costs to the system. It seems the VA somehow believes it can escape the health-care mess of the future. Without long-range planning, the duality of care for veterans will continue to decline. In effect, the Veterans Health Services and Research Administration (VHS&RA) will not only have to forego some of its legislatively authorized objectives, but will also have to continue a policy of limiting health care to veterans and continue piece-mealing programs to death.

In this budget environment of deficit reduction and given the current health-care crisis, it is obvious there needs to be a complete reassessment of the entire VA health-care system if it is to have any relevance at all to the most pressing needs of the disabled veteran population. For this reason alone, the VVA supports the proposed review of the mission and alignment of VA hospitals, clinics and other medical facilities. The Secretary of Veterans Affairs proposed "Mission Commission" offers all concerned an opportunity to know what is truly required to care for veterans as authorized under current law. We assume the purpose of this commission is neither to close medical centers nor to justify savings at the expense of veterans for purposes of balancing the budget. We also assume such a study will help us all to plan for the future of the VA system, but more importantly for the needs of service disabled veterans. Until the study is completed, we are forced to look only at what we have before us today and identify only those areas of immediate concern.

HEALTH CARE

We, along with all who serve veterans, are gravely concerned about decreasing access to VA health care. As a representative of Vietnam veterans, we are particularly concerned about what will happen to programs of treatment for PTSD, drug addiction and alcoholism, and Agent Orange related illnesses. While the VA has brought new clinical programs on line, in some cases certain budgetary problems accompany them. As an example, new PTSD treatment teams have been established but without sufficient funding and staffing support to implement them.

We must note that the realities of mental health disabilities are not reflected in the 1991 budget request. There are no additional requests over the 1990 budget for programs to assist homeless veterans. There are no additional requests over the 1990 budget for the Readjustment Counseling Service or the associated Veterans Outreach Centers. There are no additional requests over the 1990 budget for inpatient or outpatient care for PTSD.

In December of 1988, the long awaited study conducted under VA auspices by the Research Triangle Institute was finally released. The findings of that study were alarming in suggesting that the problem of PTSD among Vietnam veterans had reached epidemic proportions.

Since then, the VA has been conspicuously silent on this report, having taken scarcely any action to meet the needs of veterans with this clearly service related problem. The same silence persists in the budget proposal for fiscal year 1991.

On the other hand, the budget proposal is replete with initiatives to address the problems of aging veterans whose problems are mostly unrelated to military service. For the aging veteran population, beds are to be added, personnel are to be added, new facilities are to be added and the Secretary has identified this population of veterans as his No. 1 priority. The VVA has no quarrel with addressing the needs of aging veterans, but when addressing these needs is completely unaccompanied by even modest recognition of the needs of service disabled veterans, regardless of how old the service disabled may be, we must register strong exception.

Virtually no new inpatient PTSD units are proposed in the new budget proposal; and yet, with only 16 such units currently on line, there are waiting periods for admission in some cases approaching 2 years. As recently as January 25, a hospital director in Topeka, KS announced his intention to close the inpatient PTSD unit at that facility and convert the beds to nursing home beds. Only after this was in part played out in the press was this decision reversed.

The proposed budget for the Readjustment Counseling Services' "Vet Center" program is slated at $47.286 million, the same as for fiscal year 1990 and no new Full Time Employee Equivalents (FTEE) have been requested. How is it that this budget can boast a 9 percent increase in medical care without adding enough to even maintain a current services budget for the "Vet Center" program? What is needed, given the PTSD epidemic among Vietnam veterans in this country, is a general expansion of the "Vet Center" and inpatient PTSD program, not contraction or retreat.

It has recently been stated in the press that a war is being waged between older and younger generations of veterans. While this statement is basically untrue, if this particular budget were used as evidence of such a war, it would be seen as a war conducted by old against young. What seems more accurate is that a war is being waged pitting the service disabled against the nonservice disabled. Sadly, the service disabled are losing and this particular budget continues that trend.

The VVA strongly recommends that the Veterans' Affairs Committees request sufficient budget authority from the budget committees to accommodate the modest cost provisions of PTSD legislation, H.R. 3037, introduced last summer and pending in the House, and further recommends that this legislation be moved forward quickly. Without such action by the Veterans' Affairs Committees, the VA is unlikely to begin to meet the needs of the PTSD-afflicted veteran population.

We note and appreciate the designation of 27 PTSD treatment team (PCT) sites and the creation of the PTSD Clinical Research and Information Center involving four medical centers. We are aware that there are other goals VHS&RA has identified to be accomplished including the establishment of a Geriatric Evaluation Unit (GEU) in every medical center, achieving 25 Geriatric Research Educational Clinical Centers (GRECCs) and obtaining a more effective and efficient mental health and medical care system to name a few. It is also noted the VHS&RA expects to carry out its programs for fiscal year 1990 at a projected workload of approximately 21,325,000 outpatient visits, at a level of 1,032,569 patients treated, and with a full time equivalent employee load of 191,801 (FTEE). However, for fiscal year 1990, it does not appear likely VHS&RA will obtain additional supplemental funding even if it is required to exceed these numbers for any reason. Even for fiscal year 1991, where additional dollars are requested for VHS&RA, many of those dollars, perhaps as high as 60 percent to 70 percent will not be new. Rather, those dollars will be used to repair some of the fiscal damage VHS&RA sustained in absorbing salary raises and bringing on new programs without funding. For example, all programming relative to Agent Orange issues such as the 200,000 exams, research, education and potential clinical care, office and staff support relative to committees and operations, and beneficiary travel have been absorbed, mostly by the medical centers. If there is a "line item" for these expenses, as there is for AIDS for example, it does not show up in the 1991 budget request.

Recently the meeting of the next Advisory Committee on Health-Related Effects of Herbicides which was planned for March 21, 1990 was canceled because of budgetary constraints. Such cancellations place serious doubts in the minds of Vietnam veterans regarding the commitment and credibility of VA on the Agent Orange issue. Based on the Secretary of Veterans Affairs statements, Vietnam veterans have been encouraged to believe that compensation for some Agent Orange related illnesses would be authorized expeditiously. However, the Secretary's decision to wait until the release of the Selected Cancer's Study has raised doubts, and diminished hope. There is also legislation, currently pending in the House of Representatives, passed twice in the Senate, to give compensation for these illnesses. In the event either an administrative or legislative remedy should occur, we need to be assured that there is funding available.

Minimally, the Veterans' Affairs Committees are strongly urged to include funds for Agent Orange compensation in their requests to the budget committees. The level of funds requested should correspond to the Congressional Budget Office's

(CBO) estimates of the cost of H.R. 3004, currently pending in the House with over 140 cosponsors.

COMPENSATION AND ADJUDICATIONS PERSONNEL

The budget proposed for the 1991 fiscal year is woefully inadequate to address the most serious challenges facing veterans in their efforts to be treated fairly in their claims for benefits. While the funds requested assume that certain levels of benefits will have to be paid, this budget request is silent on the issue of how a legitimate balance between "quality" and "timeliness" in adjudications can be achieved. On this particular score, this budget is like many others we have seen in the past that simply require that more be done with less, regardless of the key questions of public administration that remain unanswered.

The fact is, the VA needs more and better trained adjudicators from the regional offices up through to the Board of Veterans Appeals (BVA). In recent years, at the behest of the Central Office, there has been a lopsided preoccupation with production (output) without qualitative input relative to staff needs and requirements to do the best job. This has come at the expense of quality in adjudications.

HOME LOAN GUARANTY

The proposed budget for the 1991 fiscal year contains a variety of proposals that are of very little use in the overall debate over how to constructively restore this program to solvency. Moreover, these proposals ignore legislative changes enacted into law since 1987, the results of which have yet to be properly gauged.

Specifically, the budget proposes a 4 percent downpayment on all loan guarantees over $25,000, elimination of the manufactured housing loan guaranty function of the program and an increase in the new indemnification fee to 1.75 percent. For anyone familiar with past proposals made in recent years for this program, this year's proposals are a transparent effort to eliminate the loan guaranty program altogether. As such, they cannot be taken seriously.

Assuming the rule of thumb in today's housing market, even this no money down program requires 5 percent up front for closing costs. Add a 4 percent downpayment and suddenly the up front cost is 9 percent. Add another two points for the privilege of borrowing from a lender and a 1.75 percent indemnification fee and we are up to 12.75 percent. Using conventional methods, securing a mortgage usually requires only 10 percent. Even if marginal benefits associated with using the VA program remained, they would be so insignificant as to suggest forgetting about the program altogether. It is clear to the VVA that this is precisely what these proposals have in mind.

In our view there are two adjustments that must be made in the home loan program. The first of these would restore the program to its original readjustment purposes by exempting first time home buyers from indemnification fees.

The second adjustment that must be made borrows from the results of a pilot program operated in Houston by the loan guaranty service between August of 1988 and July of 1989. In this program only 10 additional staff were added for the exclusive purposes of making contact with veterans delinquent in their mortgage payments and working with them and their lenders to remedy defaults in a manner preventing foreclosures.

The results of this pilot program are almost as astonishing as the fact that the results were ignored in the 1991 fiscal year budget request.

The contact with delinquent veterans increased by 105 percent. In 89 percent of the cases in which the VA intervened, foreclosures were averted by purchasing the loans from the lenders and rescheduling payments by veterans to the VA. Apart from this, there were 415 successful interventions with lenders to prevent foreclosure. Moreover, out of 13,672 contacts with delinquent veterans, 8,900 (65 percent) resulted in cured defaults. The cost of this program was a mere $378,000 and the savings to the Government in this highly depressed Houston real estate market was conservatively estimated at $11.225 million, a 3,000 percent return on the investment. Obviously, more of this must be done before any proposal to eliminate the program is seriously considered.

In suggesting that first time home-buyers should be exempt from the indemnification fee, we are well aware of the obvious programmatic concern that making adjustments in the indemnification fee's application to various categories of veterans so soon after enactment of the statute establishing the indemnification fee might be premature. However, the administration's challenge to the loan guaranty program, as outlined in the Budget proposal, extends far beyond minor modifications and goes to the heart of this program's very existence. That being so, it is entirely appropriate to respond to the administration's challenge by adjusting the program's scope in a way that makes it more defensible and brings it closer to its original readjustment purposes. Exempting first time home-buyers from the indemnification fee would accomplish this end.

S. 2101, ADMINISTRATIVE REORGANIZATION PLAN FOR TOGUS, ME LOAN GUARANTY DIVISION

The VVA generally withholds comment on planned agency management reorganizations in the spirit of avoiding participation in the micro-management of the VA's administrative operations. In some instances, however, offering comment is required by a greater concern that services to the veterans the agency is designed to serve might be adversely affected by administrative changes.

In the case of S. 2101, the VA expresses its desire to consolidate loan guaranty services into one office at Manchester, NH. In doing so the loan guaranty function at the Hartford, CT, Togus, ME and Boston, MA regional offices would be closed. In proposing this administrative change, the VA offers as justification a concern that "when work is not performed regularly, poor quality and failure to meet timeliness standards often result." The work not performed regularly to which the VA refers are functions of the loan guaranty service involving property acquisition in cases of foreclosures. True it is, the levels of foreclosures of VA-backed property are much lower in New England than in most other parts of the country. It is also true that the VA is having difficulty recruiting and retaining skilled employees in both the Hartford and Boston offices because of the high cost of living.

Given the economies capable of being achieved by consolidation as well as the overall stability of the present real estate market in New England, the VVA has no burning objection to the planned consolidation. However, we strongly urge the committee to exercise caution by fully exploring the potential future consequences of this proposed consolidation prior to approving this or some similar piece of legislation.

As the VA itself states in its justification for this consolidation, "any sudden shift in the New England economy or real estate market leading to loan terminations and property acquisitions could have negative impact on loan guaranty operations." In the context of the VA's justification, this statement is made referring to the insufficient practice of VA officials in handling property acquisitions. Nevertheless, the same negative impact may obtain if there are too few offices in the New England region to handle increased property acquisition workloads in the event of economic reversal. The history of VA's failure to counsel veterans or work with lenders to cure defaults in the early 1980's up through to the present speaks volumes about the negative consequences of being unprepared or unwilling to act decisively to prevent foreclosures and protect the solvency of the loan guaranty revolving fund.

For its part, the VA tells us that the "consolidated loan guaranty division (in New England) will be able to better handle any such market changes." What is missing in this rather sweeping generalization is any explanation or proposed plan as to just how a consolidated loan guaranty division will actually fulfill its responsibilities in the event of a market change.

COURT OF VETERANS APPEALS

On review of the budget proposed for the new Court of Veterans Appeals for fiscal year 1991, it is difficult to assess the adequacy of this request. Having opened for business only last October 16, this court still lacks a full complement of judges and still faces the need to staff up for full operations. That being so, it is strongly suggested that the Veterans' Affairs Committee make a firm recommendation to the budget committee urging that funds for the court be sufficient to meet unanticipated expenses and unexpected demands.

In this connection, we note that the budget request assumes the court will hear a caseload only barely exceeding 5,000 cases. Yet, as of this date something over 11,000 cases are eligible for appeal to the court. While the VVA is certain that the court will not be burdened with all of the eligible cases having been decided at the Board of Veterans' Appeals (BVA), in the absence of at least a full year's court operation it is impossible to predict with any certainty how many cases will actually be appealed. Under the circumstances, it would be prudent to recommend a budget figure sufficient to accommodate an exaggerated number of appealed cases. Any surpluses resulting from overbudgeting could then be either returned to the Treasury at the end of fiscal 1991 or carried over to fiscal 1992.

Travel funds are also an important aspect of the budget proposal. Most of the travel anticipated in the budget proposal is expected to be used in training. This is certainly necessary given the newness of this court, but it must be remembered that an important function intended for the court was travel for the purpose of hearing appeals in remote parts of the country. As with that part of the budget that is assumed to accommodate the number of cases appealed to the court, the travel portion of this budget should be based on an optimistic assumption that the court will regularly travel for the purpose of hearing appeals.

EMPLOYMENT AND TRAINING

Apart from the budget proposal for the VA in the 1991 request, the budget proposal for employment and training programs operated by the Department of Labor in the 1991 fiscal year also leaves much to be desired. This is most especially true of the proposed allocation for Disabled Veterans Outreach Program Specialists (DVOPs) and Local Veterans Employment Representatives (LVERs). According to the statutory formula set forth in title 38, United States Code only 1,730 of the required 1,883 DVOP specialists will be funded and only 1,465 of the required 1,600 LVERs will be funded.

THE SYSTEM ISSUE AND IMPLICATIONS FOR THE BUDGET

If the VA's medical mission is to ensure quality medical care is provided on a timely basis to eligible veterans, and if the VA's benefits mission is to ensure benefits and services are provided to eligible veterans and their families in a fair, efficient, timely and compassionate manner, then what is the VA's mission relative to those employees who carry out both the medical and benefits missions? We ask this question because the VA budget hearings inadvertently imply that someone other than VA health care and benefits employees care for veteran clients. One would think that the former VA Administrator or the Office of Management and Budget or veteran service organization leadership, even Members of Congress, had or have the responsibility for caring for veterans. You, as we, hear from these workers, but are we listening? Are we reading and utilizing the information in the suggestion boxes keeping in mind that some of the most important recommendations for improvements to a system may come from within? Are we maintaining vested interests at the expense of veterans isolated in an antiquated health-care system, reduced to telling veterans to go somewhere else for care because the system is out of money?

Those who care for veterans can make contributions to the system through their suggestions, contributions that could have real impact on the VA budget if these suggestions can override bureaucratic inertia.

For example, to centralize to only one or a few pharmaceutical distribution centers for the entire VHS&RA system probably is a poor idea. At best, it precipitates a need to build a new huge bureaucracy, creating a sole source monopolistic system potentially reducing to almost zero any flexibility for VA hospitals purchasing and waiting for drugs. More subtly, it would appear this recommendation to centralize does not appreciate current organization trends toward decentralization as a means of on-line quality delivery. Nor does the centralizing recommendation appreciate the advantages of state-of-the-art computer-driven information systems which would allow VHS&RA's individual medical centers to use inventory methodologies based on their need to purchase and obtain drugs at the best price and greatest availability.

The VA spends millions of dollars for very expensive drugs such as AZT, and experimental drugs such as Erythropoeitin which results from recombinant DNA technology. The last thing the VA should be involved in is creating noncompetitive monopolies within the pharmaceutical industry.

Further, it does appear the VHS&RA is completely unable to manage and care for veterans in an environment even moderately free from political influences. Some employees are having difficulty understanding why a regional office may have to move from Dallas, TX to Jackson, MS given the patient care mission of VHS&RA.

We understand why reimbursable insurance dollars are not returned to VA for services rendered to veterans carrying health-care insurance instead of to the Treasury. The disturbing reason is that OMB will remove additional dollars generated by the VA in future budget requests based on inflated estimates. From a public policy standpoint, it would make far more sense to shelter VA generated income from OMB tinkering and in doing so create a substantial fiscal incentive for the VA to develop a meaningful reimbursement/collection program.

The difficulty in understanding the relationship between the apparent congressional budget cut of VHS&RA's Medical Administration and Miscellaneous Operations Expense (MAMOE) budget and apparent congressional displeasure with some aspects of VA performance has been expressed by VA staff who felt these cuts were more politically motivated than motivated by concern for lack of efficiency or the quality of care.

DECENTRALIZATION; IN GENERAL

In previous testimonies, we have offered numerous suggestions for decentralizing the VA health-care system. It is becoming clearer and clearer to more and more people concerned with veterans affairs that the VA health-care system as a centralized bureaucracy is becoming increasingly dysfunctional. The Secretary's decision to abolish the 27 VA health-care districts and reduce the number of VA health-care regional offices from seven to four can only be considered a step in the direction of decentralization if VAMC directors are given greater authority for making local decisions to serve veterans.

That recommendation, in addition to those we made to the House Budget Committee's Task Force on Health last March continues to have budgetary relevance. One step is to allow each medical center to initiate and design its own annual budget plan first. This could be done within the DRG/RAM II rules, but the medical center director should be required to justify the budget requests by tailoring medical center resource needs to the veterans it serves in the community where the center is located. This may require the medical center to contract for some services and/or sell other services to non-VA hospitals or health systems in that same community. The relationship between the medical center and the Central Office should be one in which the medical center sells services for veterans to the Department of Veterans Affairs.

The current system is a top-down cost configuration in which many political layers exist, each organization layer with its own agenda. This has effectively hidden the realities of the true cost of quality health care for veterans. A bottom-up cost configuration at the medical center level, on the other hand, would give us an opportunity to determine actual costs, allow medical center management to be held directly accountable for their product, allow more realistic choices at the local level, and allow the veteran to be more meaningfully served.

We do not view our obligation to veterans to include micro-management of the VA but rather to hold the agency accountable for its product and to actively seek improvements in the system where needed. The issue of funding is a matter of priorities but we are hopeful the final determinant is quality of care.

S. 2103, THE REGIONS AND REORGANIZATION

VVA has proposed in earlier testimony that the medical regions be eliminated. Currently, DVA is awaiting congressional concurrence on its decision to reduce the number of medical regions from seven to four. Further, the department has decided to eliminate all 27 medical districts. It hopes to implement that decision by March 31, 1990.

We have recommended the elimination of the medical regions for many reasons but primarily because:

They have become too politicized; not operating in the interests of veterans.

They were being used by DVA health-care top management to avoid corporate responsibility.

They denied medical center top staff the opportunity to make decisions; that is, regional directors tended toward concentrating decision-making powers at the expense of both the management above them and the system below them.

They tended to control and manipulate dollars more to the interests of regional politics and agendas and less to the interests of medical center health-care needs.

VVA does not support the elimination of the medical districts. We clearly see a need to review the missions of the districts but acknowledge their importance as coordinating health-care planning for clusters of like-hospitals in terms of veterans health programs, demographics, shared resources—especially with regard to other Federal facilities and programs, and the communities of which these hospitals are a part.

Additionally, we perceive a special role for medical districts; namely, as guarantors of quality health care being delivered at medical centers in an efficient, safe, econometrically sound and timely fashion. This role for the medical districts can be at its most effective if DVA, at the national level, purchased veteran health care with its congressional appropriations from medical centers. The medical districts should have the primary responsibility of assuring the department that it is getting the best possible health-care product for the public dollar primarily because the medical districts are in the best position to do so.

VVA still has strong reservations with respect to the pending reorganization of the medical regions. In effect, the four remaining regions through their directors compound the matter by increasing span of control leading to a greater possibility of executive abuse and concentration of power.

The new reorganization, by creating four "mini" central offices, will move toward centralizing power in the hands of a few at the expense, once again, of the veteran and those who serve them at the operational patient-care level.

Therefore, VVA still cannot support the medical regional reorganization. Yet, we believe the four-region approach should have an opportunity to go forth provided it is clear that regional directors are not given line authority over medical directors but rather they have maximum facilitative capability to make the system work and responsive to both DVA health-care employees and veterans.

We thank you for this opportunity to present our written testimony to the Veterans Affairs Committee.

STATEMENT OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

BACKGROUND

The American Association of Dental Schools (AADS) represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. We are the only national organization concerned exclusively with the needs of dental education.

AADS is pleased to have the opportunity to submit this statement expressing our views on the Health Care and Health Research Budget for the Department of Veterans Affairs (VA) in fiscal year (FY) 1991. Our comments will focus on our concerns about delivery of dental services and dental education activities in the VA. AADS supports the overall VA health care and health research budget levels recommended by the "Friends of VA Medical Care and Health Research" coalition, of which we are a member.

RECENT AADS VA ACTIVITIES

In 1989 the AADS Council of Deans approved a strategic plan to lead to closer interactions between the dental academic community and the VA. This plan identifies opportunities for greater cooperation ranging from predoctoral and postdoctoral training to continuing education activities. A working committee of VA dental chiefs and dental school deans met on July 26, 1989 to discuss closer ties. Their goals are to improve affiliations by increasing integrated residency programs and the part-time faculty appointments of VA dental staff. A workshop to educate deans, chiefs of dental service, and medical center directors, and discuss an ideal model for affiliations, is planned for later this year.

An adequate VA health care and health research budget for FY 1991 is essential if promising initiatives are to have a chance of taking place in the near future.

Recognizing the importance of VA-dental school affiliations and the need for more information on current issues and obstacles, on February 6, 1989 AADS distributed a survey to all VA Chiefs of Dental Service. We posed questions dealing with dental school affiliations, outpatient issues, education program development, and recruitment and retention concerns, among other matters.

Key findings were that:

—Most of the significant vacancy problems in the VA dental service were in dental assisting and dental hygiene, with salary being a major reason for attrition.

—Only 52 percent of VA facilities have postdoctoral dental training, and only 10 percent have dental fellowships. Staff and workload are the main limits on expanding education programs.

—Current dental eligibility restrictions, especially in the outpatient area, are seen by many as a problem affecting educational opportunities for dental residents.

—Although only 32 percent of VA dental facilities are currently conducting research, many more were interested in developing research, but barriers such as existing workload prevented such a step.

—Most saw no major problems with dental school affiliations, but several common problems were identified by the minority. Many chiefs without a dental school affiliation felt they were located too far from a dental school to make affiliation feasible.

BUDGET RECOMMENDATIONS—HEALTH CARE

AADS supports a FY 1991 VA health care appropriation of $13.4 billion. The administration's request of $12.2 billion is a step in the right direction from proposed reductions in previous years, but is still not enough. Recent budget shortfalls have threatened relationships with all academic health centers. Increased funding is needed to prevent a decline in quality based on cumulative damage from past inadequate funding.

A. DENTAL OUTPATIENT INITIATIVES

Dental services for veterans are important because they are provided to a patient population having oral health problems that are usually more severe than those of the general population. Often the oral condition is complicated by other medical problems. The VA hospital patient—compared to the overall veteran population—is poorer and more likely to be single, disabled, older, and a minority group member. Given this special patient population, the VA needs to have well-trained primary care dentists with the sophistication to treat a myriad of complex oral health needs. In fact, many of the VA dental residency training programs focus on treating elderly patients and other individuals requiring specialized care, such as the handicapped, medically compromised, and those infected with the AIDS virus.

However, one of the largest problems with VA dental care is that veterans' eligibility for dental care is more restrictive than for medical care. One significant limitation is that medically adjunct dental care problems of inpatients can be treated, but this service cannot be provided to outpatients—even where the attending physician determines that the treatment of oral health conditions is necessary for improving the overall medical condition. Similar restrictions exist on Home Based Health Care.

The goal of our recommendations in this area is to achieve better oral care for veterans at a savings to the Federal budget. It is not often that we can find a way to simultaneously improve health care services to veterans while lowering costs.

AADS supports the administration's FY 1990 and now FY 1991 proposal to permit dental treatment to be performed on an outpatient basis to certain veterans scheduled to receive hospital treatment. This could save more than $500,000 over each of the next 4 years. The proposal would provide limited outpatient dental treatment to veterans scheduled to have certain hospital treatment (such as implantation of hip and knee prostheses) These patients would only receive dental treatment that is professionally determined to be essential for care. Currently, patients who need such limited dental treatment prior to certain types of surgery must be admitted as inpatients to be eligible for dental treatment. This results in longer periods of hospitalization and increased administrative costs for the VA. Procedures such as teeth cleaning and treatment of any existing oral infections prior to surgery can be easily performed in the outpatient setting.

To date, this provision has passed the Senate (as part of S. 13), but has not been included in House VA health care legislation. We thank this committee for supporting this important change.

AADS has recommended another change in outpatient dental eligibility that would also save money by providing needed treatment in a less expensive but more appropriate setting. Under current law, a veteran with a non-service-connected disability (unless falling into a few limited categories) who is otherwise eligible for medical care, cannot receive outpatient dental care even when the attending physician determines that treating the dental problem would improve the patient's overall health. Instead, these veterans are often admitted to VA hospitals, where dental care is provided, BUT at a greater cost than if the patient were to receive dental treatment as an outpatient. We urge the committee to also support a legislative change in this area. Potential savings here are estimated to exceed $250,000 per year. Such a change was endorsed by the Geriatrics and Gerontology Advisory Committee (GGAC) in its December 1987 report, "Oral Health Concerns of the Aging Veteran," and has now been adopted as part of the administration's FY 1991 budget request.

To provide an example of the direct health care benefit, we cite the NIH Consensus Conference in April 1989 that explored oral complications of Cancer Therapies: Diagnosis, Prevention, and Treatment. Key facts noted were that:

—Of 1 million Americans diagnosed with cancer each year, 400,000 will develop oral complications from their cancer treatments. Therapies such as radiation, chemotherapy, surgery, and bone marrow transplants can dramatically affect oral health.

—Complications include mucosal inflammation, ulceration, oral candidiasis, viral and bacterial infections, dental or periodontal infections, xerostomia, and bleeding.

These are painful, hard to treat, and may diminish the quality of life. Complications may discourage further treatment, or even become life threatening by leading to fatal systemic infection.

—Complications may extend after treatment: decreased saliva production can result from radiation therapy for neck and head cancers. Among other problems, this can lead to rampant tooth decay.

Given these problems, it was recommended that a comprehensive dental examination is needed prior to cancer treatment. Most patients will need only minor dental treatment, which is most appropriately delivered in the outpatient setting. By providing such low cost preventive and restorative care prior to radiation or chemotherapy, significant adverse consequences can be avoided. Provision of dental services in the outpatient ambulatory setting simply makes sense as the best and most cost-efficient oral health care.

AADS also supports the other important dental proposals included in the administration's FY 1991 budget request: increasing the dollar limit required for a second opinion exam, extending outpatient care to World War I veterans and all former POWS, and authorizing oral health care to veterans receiving Hospital Based Home Health Care. We urge the committee to support all of these measures.

B. GERIATRIC INITIATIVES

This is a critically important area of dental care, because of the complicated medical problems of the elderly and the growing elderly veteran population. Recent estimates project that each year an increasing percentage of veterans are 65 years of age or older.

The table below shows this trend:

[In millions]

Year	Veteran population	Veterans 65 +	Veterans 75 +	Percent 75 + veterans + 65
1990	27.0	7.2	1.5	21
1995	25.7	8.5	2.6	31
2000	24.1	8.9	3.8	43
2005	22.3	8.5	4.4	52
2010	20.5	8.2	4.4	54
2015	18.7	8.6	3.9	45
2020	17.1	7.8	3.7	47
2025	15.7	6.9	4.1	59
2030	14.6	6.0	3.7	62

Source: VA ACMD Office of Geriatrics and Extended Care.

At the same time, many more individuals 65 and over are retaining their teeth.[1] Due to this trend, it is estimated that the number of teeth at risk of dental disease in the U.S. will increase significantly, from 2.8 billion in 1975 to an estimated 5 billion in 2020.[2] Therefore, oral health care for veterans with an emphasis on prevention should cost less than attempting to restore the oral cavity to health after dental care has been avoided or denied.

Good oral health is essential for adequate diet and overall well-being. Healthy teeth contribute to the patient's ability to speak clearly and communicate. Also, a poor appearance of and discomfort related to the mouth and teeth may damage the patient's self-image and interaction with others.

To address this situation, the VA must have the number and types of personnel trained in geriatrics to serve this population.

The report on "Personnel for Health Needs of the Elderly Through Year 2020" (Sept. 1987 Report to Congress published by the U.S. Dept. of Health and Human Services), hereafter referred to as the 2020 Report, identified several different levels of needed training, including a leadership cadre of dentist-geriatricians, numbering 1,500 by the year 2000 and 2,000 by 2020, and a need for 8,000 to 12,000 dental practitioners with some advanced preparation in the clinical treatment of geriatric patients. VA geriatric programs are vital in efforts to meet these goals, since only a handful of such personnel (less than 50 in the entire United States fully trained in geriatrics) currently exist.

---

[1] A 1985-86 NIDR study found that only 4 percent of working adults age 65 and younger were missing all their teeth, and 42 percent age 65 and older (a reduction from earlier surveys) were toothless.

[2] Reinhardt, J.W. and Douglas, C.W. The Need for Operative Dentistry Services: Projecting the Effects of Changing Disease Patterns. "Journal of Operative Dentistry" 1989. 14:114-120.

Thus, AADS supports VA initiatives in this area such as:

(1) Geriatric Fellowship Program—Since 1982 the VA has operated this 2 year fellowship program (for dentists with specialized postgraduate training) at five VA medical centers (an additional center was recently added increasing this number to six). Most program graduates have been appointed to VA clinical or research positions. This program is a direct effort to meet a serious need for advanced geriatric training to provide a leadership cadre of dentist-geriatricians, as identified in the 2020 Report.

AADS supports funding to enhance the current geriatric fellowship program. Further, our association supports the expansion of the current 2 year fellowship program into a 5 year research and academic fellowship in collaboration with NIDR and the Administration on Aging. This would allow greater clinical and research experience, and greater research expertise, which has been identified as a much-needed improvement of the current program.

(2) Geriatric Research, Education, and Clinical Centers (GRECCs)—There are currently 12 centers that have strengthened research on aging by consolidating local research expertise and attracting top scientists from beyond the local area. AADS has noted that dentists may participate in GRECCs, but their participation varies by location. Although each center has one or several specialized research areas, none has a specific oral health focus. AADS has urged the creation of a GRECC with such an oral health emphasis (as recommended by the GGAC). Such an effort can only be undertaken with adequate budgetary support.

AADS recommends an expansion of the number of centers to 17. Public Law 99-166 mandates a total of 25 centers, so this would only be a partial step toward meeting this requirement. AADS also recommends that all applicants for GRECC grants should be required to show evidence of efforts to conduct cooperative education and research with area dental schools.

AADS also supports a geriatric enhancement of the general practice residency training program, described below.

C. EDUCATION AND TRAINING INITIATIVES

The VA plays a vital role in dental education, as all U.S. dental schools are affiliated with at least one VA medical center. The key educational connection is in residency training for dental school graduates. The VA is at least partially involved in the training of about 25 of Nation's dental residents (since many programs feature a VA rotation), and directly provides 10.5 percent of all dental residencies and over 16 percent of dental general practice residencies. A majority of the VA dental residency positions are in general practice, with others in oral surgery. prosthodontics, periodontics, endodontics, oral pathology, public health, and anesthesiology.

AADS remains concerned about the impact of last year's VA residency reduction, wherein 25 positions or 7 percent of total VA dental residency positions were terminated. At a time when dental education is moving toward the provision of a postdoctoral internship for all graduates who need and demand such training, this action put the VA in a compromised position concerning the future quality of its dental practitioners. While we understand the administration plans to gradually restore most of these positions over a multiyear period, we urge this committee to provide adequate funding so that these positions can be restored in FY 1991.

Adequate funding is needed here to develop several important new initiatives. Just as the VA took the lead in developing geriatric training, we believe these proposed training initiatives accurately anticipate the needs of tomorrow's VA patient population.

(1) One Year Geriatric Extension to GPR Program—An extremely important planned dental residency initiative is to allow an expansion to a second year of the 1 year general practice residency, to provide a focus on geriatrics. In contrast to the Geriatric Fellowship program, which addresses the need for a small number of highly trained academicians and researchers, this improvement is being sought to develop more general practice dental clinicians who can provide oral health care to the aging veteran population. Such a program would enhance the skills of dental general practitioners in treating the special health needs of elderly patients, and would be a step toward addressing the shortage of clinical geriatric training for health professionals.

AADS believes that such training initiatives should also focus on geriatric training of dental hygienists, as recommended in the 2020 Report. Dental hygienists play a major role in the care of the institutionalized elderly, and would benefit from programs allowing them to develop clinical and academic skills in geriatrics and the treatment of the medically compromised.

(2) Infectious Diseases Fellowships—The AIDS epidemic has had a tremendous impact on VA health care, including the VA dental service. Dental care is extremely important to the HIV infected because the signs of HIV infection often first appear in oral regions, and dentists are often the first diagnosticians to detect the disease. Recent data compiled by the VA demonstrates the importance of dealing with oral implications of AIDS. Estimates are that 72 percent of all VA AIDS patients have some type of clinical oral manifestation. Approximately 87 percent need some type of dental treatment, and approximately 63 percent are medically compromised. Nearly 55 percent of infected patients have been referred to dental service because of a dental emergency or another oral problem. Nearly 55 percent of all infected patients had a specific oral complaint that included pain on swallowing, bone pain around the teeth, canker sores, or intraoral bleeding.

To respond to these needs, AADS recommends the development of a dental fellowship in infectious diseases.

(3) Informatics—Given the increasing use of computer technology in VA dental health care, this is an opportune time for the VA to develop informatics fellowships in collaboration with the National Library of Medicine. These fellowships would allow dentists to acquire skills in utilizing existing and future information technology systems that help to improve health care. Fellows would explore areas such as utilizing the VA health care data base to determine how patient medical problems correlate with dental conditions, and learning how computers can assist in clinical-decision-making (such as checking on medications that may have an adverse impact on dental care, particularly in medically compromised patients).

VA DENTIST PAY INITIATIVE

We urge the committee to make a budget recommendation that contains sufficient funds to enhance VA physician and dentist pay. While the supply of dentists in the VA is not in an immediate crisis situation, certain trends suggests future problems. Our 1989 survey of VA Chiefs of Dental Service revealed that 9.29 percent of facilities had current dentist vacancies, and 16.4 percent of facilities had dentist vacancies during the past year. While these numbers may not seem dramatic, it should be noted that:

(a) Of facilities with dentist vacancies in the past year, 65 percent said that retirement was cited as a reason for leaving the VA. Twenty-six percent of these facilities said "better salary" was cited as a reason for leaving the VA;

(b) Seventy-eight percent of respondents cited increased salary as a valuable incentive for recruiting and retaining dental personnel.

Also noteworthy is the fact that there will be an incentive for many dentists to retire after October 1, 1990, when entire bonus pay will be included for figuring their retirement income. If VA dental attrition continues due to reasons such as retirement, then there will be an increasing need for new dental recruits. As discussed above, such individual dentists must be among the very best of dental school graduates as they will increasingly be called upon to train residents and conduct research. However, future VA dental recruitment will occur in a highly competitive environment due to significant declines in dental school enrollment and the dentist to population ratio.

In the period from 1989 to 1993, dental school enrollments—already down 37 percent in the last 10 years—are predicted to decline from 4473 to 3602. From 1994 to 1997, enrollments are predicted to decline from 3462 to 3135. Even today schools may not be training enough new dentists to offset VA retirees. Thus, the VA will need to compete for recruits in an ever tightening market.

The next 20 years will be a particularly critical period in maintaining adequate numbers of dentists. To further amplify this point, our data predicts that the dentist to population ratio will decrease from a peak of 56.6 per 100,000 population in 1987, to 43.5 per 100,000 by 2020. This means that the future is likely to consist of dental undersupply. If VA salaries do not become competitive, the future of VA dental care will be damaged.

For these reasons, we urge the committee to consider the National Association of VA Physicians and Dentists (NAVAPD) recommendations for a special pay increase and closely scrutinize the administration's pay proposals. Any proposal should adequately account for pay differentials in dentistry. There should be a comparison of how dental salary and benefits in the VA compare with the Department of Defense dental system, as well as a complete analysis of other comparable types of dental positions.

E. ALLIED HEALTH CARE RECRUITMENT AND RETENTION INITIATIVE

One area of particular concern for dental education is the supply of dental auxiliaries such as hygienists. Increased funding would allow the VA to study potential health profession shortage areas in the VA, and use funds to retain such personnel by offering increased salaries, continuing education, and advanced training opportunities.

AADS is concerned that personnel shortages may be developing in the areas of dental assisting and dental hygiene; our 1989 survey of VA Chiefs of Dental Service revealed that attrition was high for dental assistants and dental hygienists due to low salary. Therefore, money to expand the health professions scholarship program and make it available to more types of health disciplines is needed. We appreciate that the administration's proposed budget increases for these scholarships, and we also urge an increase in this area.

Budget Recommendations—Health Research

AADS supports a total appropriation of $268 million for health research in the VA. This dramatic increase is needed to offset the decline in research funding since 1985, which no doubt has had a negative impact on recruitment and retention. Costs of doing research have increased during this time, and as a result the number of merit review awards has dropped dramatically. Our recommendation would restore the research budget to the FY 1985 level, supporting 1840 research projects. The administration's recommendation of $198 million is woefully inadequate.

Some of the benefits of VA dental research are described below:

The VA operates dental research centers in Houston, TX and Ann Arbor, MI. The Houston center's research focuses on caries (dental decay) control and the salivary glands. Some examples of such research are:

—Gels which can be spread directly on teeth to prevent caries. This is vital for cancer patients and others with illnesses that make them susceptible to increased oral health problems.

—Solutions that help relieve "dry mouth," a condition common with geriatric patients and those who receive cancer radiation therapy. Left unchecked, this can lead to serious oral health problems such as caries and infections.

—Ingestible toothpaste, first attempted for use in the space program, is, as it name implies, toothpaste that can safely be swallowed. This is a valuable tool for daily oral health care for bedridden or disabled patients who cannot stand or sit before a sink to brush their teeth.

Most of these advances work their way into the commercial marketplace, providing products that improve oral health care for the general population.

Ann Arbor center research focus on dental materials. They collect data on material effectiveness at various VA sites, collections that involves dental observation of the material's effectiveness, and involves large sample sizes. It is an excellent model for future VA cooperative research efforts with dental schools.

Dental research is also conducted through the traditional method of investigator-initiated projects. However, in recent years less than 10 percent of VA dental personnel have actively pursued approved research projects. AADS supports efforts to increase the number of VA dental staff involved in individual research projects by supporting the career development program. This program provides grants to support the training of future investigators, with a goal of training researchers who will remain in the VA system. Individuals in such a program gain the technical and administrative expertise to compete for research funding. Participation of dentists is essential for increasing the ability of VA dentists to effectively compete for individual research awards. The GGAC noted in its report "Oral Health Concerns of the Aging Veteran" that in the past VA dentists—unlike VA physicians—have not been encouraged to perform research. Career development awards would be a good method of reversing this process.

AADS urges the committee to support increases for these programs in accord with our overall health research recommendation rather than accepting a decrease of $21 million in investigator-initiated study and a decrease of $1.3 million in the career development program proposed by the administration.

AADS believes that major new opportunities for dental research clinical trials are in ambulatory care and geriatrics, that dental residents can assist in the research workload and patient care (allowing more time for -VA dentists to pursue valuable research), and that there is a good opportunity for joint research with dental schools and the VA. Additional funding would also allow research in areas such as health services, focusing on dental manpower, and the impact of the dental condition on the medical condition.

Good research opportunities provide better care for veterans, career enhancement for VA dentists, and better training for VA dental residents. Excellent dental research projects are a valuable tool for the recruitment of young dentists and allied dental health personnel into the VA. Overall dental health research can be enhanced dramatically given the tremendous opportunity for clinical trials in the VA, and clinical trials are assured of success where there is a good working relationship with the affiliated dental school. Finally, it should be remembered that having excellent dental researchers and dental research projects in the VA results in better and more efficient care of oral health problems of the VA patient population.

CONCLUSION

AADS believes that the budget recommendations discussed above would provide the necessary level of health care and research for the Nation's veteran population, while utilizing resources of the VA (in cooperation with U.S. dental schools) to provide better training opportunities for the Nation's dental health professionals.

AADS thanks the committee for considering these comments.

STATEMENT OF THE ASSOCIATION OF PROFESSORS OF MEDICINE

Mr. Chairman and members of the committee, the Association of Professors of Medicine is pleased to have the opportunity to comment on the fiscal year (FY) 1991 budget for the Department of Veterans Affairs (VA) submitted by the Bush administration. The APM will confine this statement to the medical care and medical research sections of the VA budget.

One of the pillars of the VA health care enterprise is the symbiotic relationship that presently exists between a number of veterans hospitals and academic medicine. Representing the chairmen of the departments of medicine at the 126 American medical schools (103 of which have formal affiliations with VA medical centers), the members of the APM are acutely aware of the importance of adequate funding for the VA: first and foremost because of its importance to the provision of quality health care services to VA patients; and also for its affect on the training of residents and interns, the conduct of biomedical research, and the overall operational capability of departments of medicine.

When examining the FY 1991 administration budget request for the VA, the association is both encouraged and distressed. On the positive side, the administration is requesting a medical care appropriation of $12.23 billion, an increase of slightly more than $900 million from FY 1990. This budget will support 8,350 medical residency positions during the upcoming fiscal year, the same as FY 1990. The association is pleased that the administration is requesting over $10 million in new funding for increases in VA residents' stipends. Given the often huge financial debts facing young physicians, it is critical that they be provided with at least adequate funding during their residencies to keep themselves afloat until more substantial income is realized. We urge the committee to include the funds for the proposed stipend increase in its recommendation to the House Budget Committee.

Nevertheless, the APM believes the medical care budget requested by the administration is, overall, inadequate to meet the current needs of the VA health care system. Along with the other members of the Friends of VA Medical Care and Health Research, as well as the organizations supporting the VSO Independent Budget, the APM recommends a FY 1991 medical care budget of $13.4 billion. We believe funding at this level will allow the VA to maintain the quality of its current medical care effort, as well as develop models for compensation reform for VA physicians and other health professionals without cutting patient care service delivery. The APM also believes that our recommendation will permit the VA to meet the needs of an increasingly geriatric patient population, as well as fund the stipend increase mentioned earlier.

Of equal, and in some ways more pressing, concern to the APM is the VA medical care budget for the current year. Indications are that funding provided for the medical care account for FY 1990 will not be sufficient to meeting the needs of the system between now October 1. A significant number of APM members have informed the association of reductions in support services as well as funded faculty positions. Worse yet, for the first time it is being said that the quality of care is suffering. The association is dismayed that VA Secretary Derwinski has categorically refused to seek a supplemental appropriation for the current fiscal year. The APM believes that it would be a repudiation of the commitment made to veterans if the unwillingness to seek a supplemental appropriation is in any way tied to the approval of the FY 1991 VA budget request by the upper echelons of the administration. If VA medical care suffers to even the smallest degree, this would too high a price to pay.

Turning to the request for the VA research program made by the administration, the APM is extremely disappointed with the proposed funding for this program for FY 1991. The association is shocked and dismayed that a program whose critical importance to the health care needs of veterans has been so clearly documented is slated for cuts of over $14 million. Worse yet, it is inconceivable why the medical research component, which annually produces internationally recognized and awarded scientific discoveries, is being proposed for a 9 percent, or $16 million, reduction.

This committee is well aware from previous hearings about the benefits to veterans of the three components of the VA research effort—medical, prosthetic and rehabilitation, and health services. These benefits include not only the quality science produced from the research itself (which focuses on the needs of veterans), but a positive impact on the recruitment and retention of high quality physicians to the VA system through the attraction of the opportunity to conduct research. The VA research budget proposed by the Bush administration would essentially wipe out gains made in this area over the last 2 years, taking the program back to its FY 1987 level. The President has pledged support for the highest quality of health care services for our Nation's veterans; the FY 1991 budget request for VA research calls that pledge into question.

The APM feels strongly that an adequately funded VA research program is essential if excellence in VA medical care is to be maintained. We join with the other members of the Friends of VA coalition in recommending a FY 1991 medical and prosthetic research budget of $268 million. While this is a substantial increase, both over the FY 1990 level and the administration request, it must be noted that: funding the program at $268 million will simply allow the program to return to its FY 1985 level of research project awards; and, it will correct for past inconsistencies and shortfalls in VA research funding during FY 1986-90. It should also be noted that the APM recommendation for VA research will allow for modest expansion of the Career Development Award program, the research training mechanism of the VA. The evidence is clear that this program has been enormously successful in keeping quality personnel at the VA, with fully two- thirds of its awardees since 1980 staying within the system. It is clear that VA research funds act as highly leveraged dollars.

As mentioned at the beginning of the associations's statement, one of the paramount features of the contemporary VA health care enterprise are the affiliations between VA medical centers and medical and other health professions schools. The establishment of an academic environment at the affiliated VA medical centers (multiplied by the presence of residents and interns) has brought the latest advances in medical methodology, technology and research to bear on the care of veteran patients.

At the core of the dually beneficial relationship is the joint appointment of physicians between medical schools and the affiliated VAs. By granting prospective VA physicians the opportunity to gain access to the accoutrements of the academic medical arena, the VA has realized a vast improvement in both the quality of the physicians serving VA patients and the quality of care delivered to veterans. The VA/medical school partnership also allows VA patients the opportunity to be under the care of physicians in highly specialized and scarce medical specialties and subspecialties. In departments of medicine at affiliated medical schools, an example of a physician to whom VA patients might not otherwise have access were it not for the affiliation would be cardiologist with a specialty in electrophysiology. Thus, the partnership with academic medicine gives the VA patient the opportunity to be treated by the most sophisticated level of medical care.

Most medical schools and their departments attempt to maintain a reasonable degree of salary parity between VA faculty and institutional faculty, although there can be substantial variances among institutions. This is undertaken in order to foster a spirit of parallelism and equity among the faculty of the two institutions. It is important to bear in mind that VA salaries for junior faculty are in most cases higher than in the academic institutions, whereas VA compensation for middle level and senior faculty physicians is generally less than in academia. In order to retain quality, experienced clinicians as part-time VA physicians, medical school departments must often provide salary supplements to faculty who work, both part-time and full-time, at the VA. The APM is in the process of gathering data on salary supplements and other financial aspects of the relationships between departments of medicine and affiliated VAs. The association will be happy to share or present this information to the committee as soon as it is compiled.

In summary, the relationship between VA medical centers and academic medicine creates a symbiosis and a synergism that, at the bottom line, means better care for VA patients. Both academic medicine and the VA have fostered under the present relationship, and the APM urges the committee to oppose any steps to weaken this vital national resource.

The APM thanks you, Mr. Chairman and the members of the committee, for this opportunity to submit our views. The association looks forward to continuing to work with you and your staff in the future. Please contact Mr. Jim Terwilliger, APM's Executive Director/Director of Government Relations, at (202) 857-1158 when we can be of assistance.

STATEMENT OF HON. CHARLES E. BENNETT, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

Mr. Chairman, prior to coming to Congress 41 years ago, I enlisted in the Army, and served our country for 5 years during World War II. I lost many friends during our country's epic struggle. I, and many of my comrades in arms, were physically hurt while performing our military service. Like many of my colleagues from that war, and previous and subsequent wars, many of us continued to need medical attention and care long after the battles were over, and after the weapons of war were silenced.

Today, thanks to the Department of Veterans Affairs, the hundreds of thousands of veterans who have served in the United States Armed Forces have an ally they can turn to for help, for counseling, and for medical treatment. Because the Department of Veterans Affairs plays such an important role in the lives of the men and women who have gloriously served in our country's armed services, it pleases me to see the administration proposal to increase VA funding in the FY 1991 budget. I thank Secretary Ed Derwinski for his fine leadership at the helm of the department and for his efforts on behalf of our veteran community.

However, one particular proposal in the FY 1991 budget has me especially concerned. That is the proposal to reorganize the Veterans Health Services and Research Administration to reduce the regional offices from seven to four, and to completely eliminate the 27 medical districts. While I can appreciate the desire to streamline the management of the Veterans Health Services and Research Administration, I am concerned that making such significant cuts will negatively impact on the care provided veterans.

I also fear that retaining only 4 regional offices, to do the work presently done by 7 regional offices and 27 district offices, may have the opposite effect desired and may create more difficulties as the four regional offices attempt to understand the problems, and nuances, of the individual communities where veterans receive care. With care providers all competing for one scarce resource, the single regional office, individual medical facilities may find it more difficult to have input into policy decisions that affect not only the facility, but the veterans population it serves.

I would hope that the idea of eliminating all but the four regional offices can be given up.

STATEMENT OF THE CALIFORNIA ASSOCIATION OF REALTORS

As President of the California Association of Realtors the statewide trade association representing the interests of over 140,000 real estate licensees, I am grateful to have the opportunity to present C.A.R.'s perspectives on the provisions of President Bush's FY 1991 budget relating to the VA Home Loan Guarantee Program. This testimony is submitted in conjunction with that presented by the National Association of Realtors. The business activities of C.A.R.'s membership involve the brokerage of real property as well as providing assistance to homebuyers in securing mortgage financing for their purchases. It is this business focus and the attendant importance of the VA program in meeting the needs of California's veteran homebuyers that motivates C.A.R.'s active interest in the issues presently before the Veterans Affairs committee.

I. INTRODUCTION

Because of the program's low closing costs and no-downpayment feature, VA guaranteed financing plays an indispensable role in the California housing market. C.A.R.'s data show that more than 25,000 new and existing homes were purchased by California's veterans with the aid of VA guaranteed financing in 1989. If refinance loans are included, the number of veterans assisted by VA financing is even greater. As evidenced by these numbers, the VA Home Loan Guarantee Program plays an important role in addressing the ownership housing needs of California's first-time and moderate-income veteran homebuyers. The role of Government-supported financing in meeting these needs has become even more crucial in recent years because of more stringent underwriting requirements imposed by secondary mortgage market investors and conventional lenders. Unfortunately, in spite of an increasing need for low-downpayment financing, the percentage of VA-guaranteed loans in the California market has dropped precipitously since 1986, from 8 percent to only 3 percent in 1989.

During the past 2 years alone, home prices in California have climbed more than 40 percent, consistently outpacing price increases in the rest of the Nation. By the end of 1989, the median price of a resale home in California was $196,521, more than double the national median sales price of $93,100. The persistently high rate of price appreciation in California has sharply increased downpayment and income requirements, making homeownership exceptionally difficult for California's veterans, particularly first-time homebuyers. These are precisely the problems that the VA program helps to address, but fewer than one-third of homes sold in California in 1989 fell below the maximum VA loan amount of $144,000. Thus, although the program has helped thousands of California veterans achieve the dream of homeownership, thousands more in high cost areas are unable to take advantage of VA financing.

As shown in Exhibit 1, the VA program offers several key advantages to conventional financing that make homeownership possible for first-time and moderate-income veteran homebuyers. In 1989, exactly 50 percent of newly-originated VA loans in California went to buyers purchasing their first home. In addition, half of the VA buyers in 1989 were assisted in the purchase of their home by using of the program's no-downpayment feature. Buyers of limited means were also assisted by the VA program's low closing costs. Finally, the importance of the VA program to moderate income buyers is illustrated by the fact that the median income VA borrowers was $25,000 less than their counterparts using conventional financing. These statistics clearly demonstrate the vital role that the VA Home Loan Guarantee Program plays in helping California veterans.

EXHIBIT 1—CHARACTERISTICS OF NEWLY-ORIGINATED CONVENTIONAL AND VA GUARANTEED MORTGAGES IN CALIFORNIA: 1989

Characteristic	Conventional	VA
Median interest rate (percent)	[1] 9.75	10.5
Median loan amount	$157,250	$116,000
Median sales price	210,000	117,500
Median downpayment	44,000	250
Median fees/points	2,814/2 pts.	1,380/1 pt.
Proportion of first-time buyers (percent)	38.5	50
Median annual household income	65,000	40,000
Median loan-to-value ratio (percent)	79.5	99.8

[1] Includes both fixed- and adjustable-rate loans.

Source: C.A.R. Housing Finance Survey.

Before proceeding to our specific comments on the President's budget, the California Association of Realtors would like to commend the Veterans' Affairs Committee for the enactment of the Veteran's Home Loan Indemnity and Restructuring Act. The new law will help preserve the VA Home Loan Guarantee Program and stem the recent financial losses. In particular, we thank the committee for the role it played in achieving the entitlement increase included in the new law, which, once implemented by the Government National Mortgage Association, will help the VA program address the housing needs of veterans in high cost markets such as California. Unfortunately, GNMA has delayed amending its loan eligibility criteria to permit no-downpayment VA loans of up to $184,000 (i.e.; four times the new maximum entitlement of $46,000) to be included in GNMA mortgage securities. As a result many California veterans remain locked out of the state's high cost urban housing markets. C.A.R. encourages Congress to urge GNMA to expedite an increase in the maximum VA loan amount so that veterans may take full advantage of their much-deserved increase in entitlement.

II. FY 1989 Issues

A. VA LOAN FEE

The California Association of Realtors adamantly opposes President Bush's proposal to raise the VA funding fee from 1.25 percent of the loan amount to 1.75 percent of the loan amount. As the committee is well aware, increases in the VA loan guarantee fee have been repeatedly proposed by the administration and rejected over the past decade. We ask Congress to reject this year's proposed increase as well.

We must emphasize that the VA loan fee was increased from 1 percent to 1.25 percent less than three months ago with the enactment of the Veterans Home Loan Indemnity and Restructuring Act. Before any increase in the current 1.25 percent fee is even considered, the major reforms enacted last year should be given an opportunity to help reduce losses and place the program on sound financial footing. It would be patently unfair to propose such a substantial hike in the loan fee when last year's increase has only recently gone into effect. If the Congress takes any action on the loan fee issue this year, it should provide for a long-term or permanent extension of the current 1.25 percent fee. The VA Home Loan Guarantee Program should not be subject to political forces regularly seeking fee increases in the name of deficit reduction that in fact would add only negligibly to Federal coffers. The VA program is an entitlement program honoring the Nation's veterans and rewarding them for the sacrifices made while in service to the Nation.

B. PROPOSAL TO REQUIRE A DOWNPAYMENT ON VA LOANS

C.A.R. also opposes the President's plan to require a downpayment of 4 percent on VA loans over $25,000. Again, we believe the VA program is an entitlement program and it would defeat the purpose of the program to require a downpayment on VA guaranteed loans. Moreover, the graduated fee reduction provisions of the Veterans Home Loan Indemnity and Restructuring Act should be allowed to become fully effective before mandatory downpayment requirements even are contemplated. As the committee knows, last year's VA bill provides for a reduction in the VA loan fee from 1.25 percent to 0.75 percent if a 5 percent downpayment is made, and to 0.50 percent if a 10 percent downpayment is made. This provision will encourage those veterans who can afford it to make downpayments on their purchases whenever possible, without actually mandating a downpayment as proposed by the President. At the same time, veterans unable to pull together the necessary funds for a downpayment would still be able to use their entitlement.

Consequently, C.A.R. also opposes the President's proposal to eliminate the sliding scale reductions in the VA loan fee when veterans make downpayments of 5 percent or more. By encouraging veterans with ample savings to make downpayments of 5 to 10 percent, this feature of the 1989 act should contribute to lowering the risk of the new Indemnity Fund, while preserving the no-downpayment feature for those veterans who need it most. Again, we think it would be ill-advised to tamper with the new law so soon after its enactment.

III. GNMA Guarantee Fee Increase

While budget provisions for the Government National Mortgage Association are not officially within the purview of the Veterans' Affairs Committee, C.A.R. would like to take this opportunity to express its opposition to the President's proposed increase in the GNMA guarantee fee from 6 basis points to 10 basis points. This user fee increase would cut into lender's servicing income and reduce participation in the VA program. In addition, although the guarantee fee increase would be paid by GNMA issuers, some lenders undoubtedly would attempt to recoup at least a portion of the fee by boosting so-called "garbage fees." These miscellaneous fees are tacked on to buyers' and sellers' closing costs at the close of escrow, when neither party is in a position to question the nature of the charges. Other lenders will simply absorb the fee as yet another increased cost of participating in the VA program.

If the GNMA guarantee fee increase is enacted in concert with President's proposal to increase risk-sharing with VA lenders, the number of lenders participating in the VA program will decline substantially. Any reduction in the availability of VA loans would be to the detriment of the Nation's veterans. Many lenders are already reeling from losses caused by the high volume of VA "no bids," on which the average "hit" approaches $20,000. With the increase in "no bids" already pushing some lenders out of the VA market, it would be inadvisable to increase the GNMA guarantee fee and accelerate the withdrawal of lenders from the VA program. We encourage members of the Veterans' Affairs Committee to contact their banking committee colleagues and urge them eliminate the guarantee fee increase from the final HUD budget.

IV. Other VA Issues

A. NEGOTIATED VA INTEREST RATE/POINTS

Although establishing negotiated rates and points is not proposed in the FY 1991 Bush budget, C.A.R. encourages the Veterans' Affairs Committee to consider repealing the requirement that the Secretary of Veterans Affairs set the maximum allowable interest rate on VA home loans. Interest rates on VA loans should be subject to the same market forces that impact rates in the conventional market. In recent years, heightened volatility in the Nation's capital markets has caused temporary sharp increases in interest rates, which reduce substantially the flexibility of VA financing in addressing the needs of veteran homebuyers.

Unlike the FHA program, which deregulated the administered interest rate in November of 1983, the maximum interest rate on VA-guaranteed loans is still administratively set. Consequently, movements in the maximum rate frequently lag behind market rates. Because VA borrowers are limited to paying no more than a one point origination fee, recent history has shown that when market rates substantially exceed the VA ceiling rate, sellers marketing their homes to veteran buyers are often forced to pay discount points to lenders that sometimes approach 6 or 7 percent of the loan amount. As a result, sellers have become extremely wary of buyers using VA financing, and these vets often are put at a severe disadvantage in the market compared to buyers using conventional or FHA financing. Moreover, sellers often will only sell to veteran buyers if the price offered is sufficient to compensate for actual or potential discount points. In other words, sellers often "pad" sales prices when accepting a VA borrower's offer.

C.A.R. believes this practice could be minimized by making the interest rate and/or discount points on VA-guaranteed loans subject to negotiation between the veteran, lender and seller. Lender and borrower experience with freely negotiable rates and points on FHA loans generally has been quite positive. A similar deregulation of interest rates on VA-guaranteed loans would place veteran buyers on equal footing with buyers using conventional financing and improve the flexibility and effectiveness of the VA Home Loan Program. Together with an increase in the maximum VA loan amount, we believe that establishing negotiable rates and/or points on VA loan could restore the VA market share in California and put thousands of additional veterans into homes.

V. Conclusion

The California Association of Realtors appreciates the opportunity to comment on the important issues before the Veterans' Affairs Committee. Because of the reduced availability of high loan-to-value ratio loans in the conventional market, the VA Home Loan Guarantee Program continues to provide many moderate-income and first-time buyer veterans with their only chance of owning a home. We appreciate the work the committee has done in the past in strengthening and preserving the program, and making it more responsive to the needs of the Nation's veterans. If you have any questions concerning our testimony, please do not hesitate to contact either Leslie Appleton-Young, Vice-President of Research, Economics and Policy Analysis, at (213) 739-8325, or Pete Mills, Manager of Research and Policy Analysis, at (213) 739-8272.A

STATEMENT OF HON. THOMAS A. DASCHLE, U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA

Mr. Chairman, I am pleased to have the opportunity to testify today before the Senate Veterans' Affairs Committee on the President's FY 1991 budget request for the Department of Veterans Affairs. I commend Senator Cranston and my distinguished colleagues who serve on this committee for their dedication and vigilance in protecting the rights and benefits of our Nation's veterans.

Many of us here today have testified before your committee at similar hearings in the past, each time reiterating our displeasure over the previous administration's budget requests for the VA. At the same time we were criticizing those budget requests, we, along with the members of this committee, were being assured that the welfare of our Nation's veterans was among the President's top priorities and that adequate funding was being requested to meet the growing needs of the veteran population.

Contrary to what the past administration may have wanted us to believe, the fact of the matter is that it successfully carried out an unprecedented assault on veterans' programs and benefits. In the 1980s, we witnessed budget requests that failed to even keep pace with inflation and double-digit increases in the cost of medical care at a time when the aging of our veterans population placed increasing demands on the VA health-care system.

One doesn't have to be a rocket scientist to determine what place the Nation's 27 million veterans occupied on the previous administration's list of spending priorities. In 1975, VA medical funding represented 5 percent of the total national budget. Now, it represents less than 2.5 percent. While health-care funding for the VA stagnated, veterans watched funding for other health-care programs, like Medicare and Medicaid, soar by 55 percent and 32 percent respectively.

Many of us recall President Reagan asking Americans whether they were "better off today than they were 4 years ago." Unfortunately, the resounding cries of "NO" from veterans throughout the country fell on deaf ears.

Mr. Chairman, America's veterans are not better off today than they were 4 years ago. In fact, their status seriously deteriorated in the late 1980s as the Reagan administration requested health-care budgets that left VA medical centers with little choice but to turn deserving men and women away.

The Department of Veterans Affairs does not keep "official" statistics of exactly how many veterans seeking medical care have been turned away from VA medical facilities as a result of the "means test" implemented in 1986 at the administration's urging and accumulated budget shortfalls. However, VA officials estimate that during the first 5 months of this year around 170,000 veterans were denied care because of budget limitations and bed closings. Others suggest that as many as 120,000 veterans a week are being denied VA health care.

To the bureaucrats sittings at their desks in the bowels of the Department of Veterans Affairs, these may be just statistics, not worth tracking for the "official record." But, to veterans and their families in my State, they represent untold stories of human heartache, grief and unfulfilled promises.

Because the Department of Veterans Affairs does not keep track of these veterans, I have been collecting the names of veterans in my State who have been told they can no longer rely on the VA for their health-care needs. The 5-inch stack of letters I have received graphically demonstrates the extent of the VA health-care crisis that exists in South Dakota. The letters, full of both pain and anger, share stories of empty Government promises and allude to the fear of growing old without the financial means to purchase private health insurance or receive needed health care.

Recent VA budget shortfalls have taken a severe toll on VA health-care professionals as well as on veterans. The previous administration blatantly ignored congressionally mandated levels of VA health-care professionals when its budget requests failed to recognize the growing shortage of VA health-care professionals. Just last year, the administration submitted a budget that provided for 8,526 fewer VA health-care professionals than mandated by Congress.

At the same time VA medical directors in my State are told they cannot hire additional health-care personnel because of budgetary constraints, they are also being told to take an annual "productivity cut." For example, the medical director at the VA medical center in Hot Springs, SD, has been forced over the past 3 years to reduce his already "bare bones" staff by over 24 health-care professionals. These staff reductions have occurred at a time when the facility's patient load was steadily increasing. Surely, the administration can find a more acceptable means to reward productive VA medical facilities throughout the country.

While the legacy of the previous administration's attitude toward veterans medical needs continues to take a severe toll on many veterans and VA health professionals throughout the country, I come before this committee today with a sincere belief that we finally have an official leading the Department of Veterans Affairs who has taken sides with the Nation's veterans in the annual budget battle. I give Secretary Derwinski significant credit for a good start in reversing the downward trend in VA medical care funding.

I am pleased that the Bush administration's FY 1991 budget proposal earmarks $12.28 billion for the VA medical care account. This figure represents an 8.4 percent increase over the amount appropriated for FY 1990. The administration's FY 1991 budget request recognizes the shortcomings of the Reagan administration's policy toward veterans, which misrepresented the funding needs of the VA health-care system and submitted budgets to Congress that dangerously undermined the stability of the VA health-care system.

Mr. Chairman, even with the infusion of funding proposed by the administration, we would be remiss to assume that all is well with the VA health-care system. It is projected that even with the additional $1 billion in the administration's FY 1991 request, the VA health-care system will suffer a shortfall of nearly $600 million. I am concerned that under this budget scenario an increasing number of veterans in my State and across the country will be turned away from VA medical centers.

While the President's request for an additional 2,300 new health-care employees is welcome news, my enthusiasm is somewhat dampened by the fact that the administration wants to divert 500 of these new employees from providing medical care to enforcing stringent new collections guidelines under its plan to collect revenue from insurers of veterans who are required to pay for their health care. The VA would be better served to keep its own work force focused on patient care rather than enter them in the business of bill collecting.

I am confident that Congress will build upon the administration's FY 1991 funding request for VA medical services to both restore veterans' confidence in our VA health-care system and deliver the kind of quality care to which they are entitled. I look forward to the Senate Veterans' Affairs Committee's recommendation for FY 1991 funding for this purpose.

On another note, Mr. Chairman, I want to reiterate my deep concern about the Federal Government's unresponsiveness to veterans suffering from diseases associated with exposure to Agent Orange, and my strong belief that funding for disability compensation to those veterans must be made available in the VA budget. S. 1153, the bill you, Senator Kerry, and I have coauthored, would authorize interim disability benefits to Vietnam veterans suffering from soft-tissue sarcoma and non-Hodgkin's lymphoma, establish a procedure through the National Academy of Sciences for reviewing all scientific evidence relating to Agent Orange, and provide other means of continuing and improving Agent Orange-related research, treatment, and outreach.

S. 1153 has passed the Senate by an overwhelming vote and is now pending, along with similar legislation offered by Rep. Lane Evans (H.R. 3004), in the House. It is vitally important that the Veterans' Affairs Committee's FY 1991 recommendations to the budget committee include sufficient funds to implement the programs and compensation outlined in H.R. 3004. It will be equally important for any future legislation authorizing VA entitlement spending to accommodate the full cost of the Agent Orange legislation.

There is no reasonable excuse for the treatment Agent Orange veterans have suffered at the hands of the Government that called them to service. The cost of our legislation has been well justified and is minimal when compared to the overall VA budget. I look forward to working with your committee as well as the budget committee to ensure that budgetary concerns are not used as a means of undermining our efforts to address this very serious issue.

Finally, as we begin work on meeting the needs of veterans in FY 1991, we must not forget the thousands of deserving veterans who won't be able to survive until next October when the VA will receive its increased appropriation. Current projections are that the Department of Veterans Affairs will face a budget shortfall of $252.4 million before the end of the current fiscal year. It is my hope that the administration will work with Congress to ensure that supplemental funding is appropriated to head off this impending crisis. Without supplemental VA medical funds for FY 1990, I am afraid all our good intentions for FY 1991 may be too late for many of our Nation's veterans.

Thank you.

STATEMENT OF HON. DANTE B. FASCELL, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

Mr. Chairman, I appreciate having this opportunity to join with the distinguished senior Senator from Florida in expressing my concern about the Department of Veterans Affairs proposed reorganization of the management structure of the Veterans Health Services and Research Administration.

While Secretary Derwinski is to be commended for his attempt to ensure that consistent health-care policies are established so that all veterans are treated equally, I am concerned that the elimination of the present 27 medical district offices, coupled with the increased size of a reduced number of regional offices, could result in an unwieldy administrative structure that might not be as rapidly responsive as the seven present regional offices.

While I am certainly supportive of constructive measures to reduce bureaucracy and streamline health-care delivery for all veterans, I am hesitant about management recommendations which may subsequently be made when so many major cities with large concentrations of veterans will be competing for the attention of a reduced number of regional offices. Therefore, I hope that the size of these new regions and their ability to serve our veterans adequately will be very carefully scrutinized and evaluated.

Friends of VA
Medical Care and Health Research

VETERANS AND THEIR FAMILIES SPEAK OUT AT CONGRESSIONAL HEARINGS

"After my husband, Silvio, was diagnosed with Alzheimer's disease, he was able to take part in a clinical drug study conducted at the Bronx VA. We have had an excellent experience there. We received outstanding care from the dedicated professionals in the research program. Here too the research program is important. In my view, it is primarily the opportunity to do research that attracts professionals of such high caliber to the Bronx VAMC."

- Nancy Falco
Hawthorne, New York
(Mr. Falco served in Europe in World War II
and was decorated with the Silver Star.)

"After I had heart failure four years ago, I began participating in a heart research program at the VA in Little Rock. After treatments, I now can do anything I want to. As far as I am concerned, they have given me a much better quality of life. I received the best of care and am treated like a person – not just a number. Being a religious man, I asked my God what He would like me to say to you. He would have me say: 'Please – a little less for research to kill and a little more for research to give life.'"

- William Insull
Altus, Arkansas
(Mr. Insull served in the Marines in the Pacific
from 1940 to 1946.)

"Because of VA research, I have tremendous advances over the past twenty years and I am very pleased with them. For instance, this kind of activity 20 years ago would have been unheard of. Also, I would like to comment that because of the research of this type, from the taxpayers' standpoint, I think the inputs you make in research now are going to translate themselves back to much quicker production of limbs and a much more efficient use of our services in our VA hospitals at a point down the road."

- Lem Nichols
Seattle, Washington
(Mr. Nichols was a helicopter pilot in
Vietnam and lost his leg in combat.)

"When it was determined that I had high blood pressure, I enrolled in the VA research program for hypertension. The service we get is very good. I am aware that hypertension is sometimes called the silent killer. But I have been involved in the Birmingham VA program since 1977 and it is controlling my blood pressure."

- Talmadge Foster
Birmingham, Alabama
(Mr. Foster served in Korea and Vietnam
for twelve years.)

PHYSICIANS VOICE THEIR CONCERNS BEFORE CONGRESS ABOUT VA FUNDING

"As chief of medicine, I spend a major portion of my time in recruitment of new staff physicians and in the nurturing and development of an active staff. I can say without reservation that the single most important factor that makes VA staff positions attractive is the opportunity to be involved in clinical research . . . The research program serves as the intellectual carrot that attracts some of our best and brightest physicians to treat veteran patients."

- Dr. Joseph H. Bates
Chief of Medical Services
Little Rock VAMC

"It is increasingly difficult to recruit new physicians as well as satisfy the needs and interests of our current staff . . . Over time the VA has lost increasing numbers of physicians and has not been able to attract the same number of physicians of similar caliber. Fiscal constraints and deteriorating physical conditions have made the VA a less inviting environment in which to practice."

- Dr. John J. Hutton
Dean
University of Cincinnati
College of Medicine

"There is increasing difficulty in attracting young physicians into academic medicine and research, in part because of severe competition for research funding and the great financial rewards of private practice. The VA will never be able to compete (nor should it) in terms of salaries, grand surroundings, or intellectual environment with strong University based departments. Having an adequate research budget in the VA seems to be a relatively inexpensive way to offset these disadvantages. If the advantages of the VA were to be reduced, many of my colleagues would leave."

- Dr. Brian B. Hoffman
Associate Professor of
Medicine and Pharmacology
Stanford University
School of Medicine

"VA research opportunities just aren't what they used to be. People who were certain to be funded five or six years ago are going without support. They would like to pursue careers in the VA but there's just too much uncertainty. We're losing excellent people."

- Dr. Joseph John
Division of Infectious Diseases
South Carolina VAMC

EXECUTIVE SUMMARY

MEDICAL CARE

For FY-1991, the Friends of VA Medical Care and Health Research recommend a **medical care appropriation of $13.44 billion.** Small measures of growth over the FY-1990 current services level of $12.1 billion are included in the recommendation: an expanded extended care program ($169 million), increased use of outpatient clinics ($165 million), new equipment purchases ($100 million), and a revised physician compensation formula ($50 million).

HEALTH RESEARCH

For the upcoming fiscal year, the Friends of the VA recommend an **appropriation of $268 million for VA health research.** This recommendation includes a baseline research budget of $252.5 million, consisting of $219 million for medical research, $23.2 million for rehabilitation research, and $9.3 million for health services research. Also included is $15.5 million for special reserach initiatives such as AIDS research, research on mental illness, and a nerve regeneration center.

	FY-1990 Actual	FY-1991 President's Request	FY-1991 FOVA Recommendation
Medical Care	$11.32B	$12.2B	$13.4B
Health Research	$212.6M	$198.5M	$268.0M

The Friends of VA Medical Care and Health Research is a diverse coalition of over 60 organizations interested in and committed to maintaining the high quality of the VA health-care system. The purpose of this document is to explain briefly to the Congress the importance to veterans and the general public of the VA medical care and research programs, and to highlight the funding needs of these programs for FY-1991.

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

TABLE OF CONTENTS ii

MEDICAL CARE

VA Mission 1

Challenges to the System 1

Recommendation for FY-1991 3

Preparing for the Future 4

HEALTH RESEARCH

A Record of Sucess 6
    Graph I 7

Efforts to Improve the Veterans' Health 7

Recent Funding Constraints 8
    Graph II 8

Recommendations for FY-1991 9

MEDICAL CARE

Mission of the Department of Veterans Affairs

On October 14, 1988 President Ronald Reagan signed landmark legislation creating the Department of Veterans Affairs. Through the Department of Veterans Affairs, United States operates the most comprehensive system of assistance for veterans of any nation in the world. Congress originally established the Veterans Administration as an independent agency in 1930 to "consolidate and coordinate government activities affecting war veterans." The VA was given a specific mission, to administer the programs and to provide the services needed by our nation's veterans and their dependents. The VA carries out a major portion of its congressionally-authorized mandate through the Veterans Health Service and Research Administration (VHSRA). A network of 172 medical centers, 231 outpatient clinics, 117 nursing home care units, and 27 domiciliaries makes the VHSRA the largest health-care delivery system in the free world. VHSRA has four statutory missions:

1. To develop, maintain and operate a national health-care delivery system for eligible veterans;
2. To administer a program of education and training for health-care personnel;
3. To conduct a program of medical research; and
4. To furnish health services to members of the Armed Forces during a war or national emergency.

In recent years, however, the level of federal funding provided has been inadequate to meet the needs of the medical care program. Even with supplementation by outside sources, the medical care account has faced a serious and destablizing budget shortfall.

Challenges to the System

The FY-1991 budget debate begins as tremors are heard nationwide about deterioration in the quality of the Department of Veterans Affairs health-care system. In his first official appearance before Congress as Secretary of the Department of Veterans' Affairs, Edward Derwinski acknowledged that the VA health care system faces "serious" and "troublesome" problems. VA Chief Medical Director, John Gronvall, M.D., also testified to Congress in 1989 that inadequate funding has had a "negative impact" on the Veterans Health Service and Research Administration (VHSRA).

Infrastructure

Practioners inside the system agree, as working conditions have declined, so has staff retention and morale. Witnesses told a congressional committee that equipment and construction funds that have been "cannibalized" in the VA in order to meet the payroll. Outmoded equipment and facilities have frustrated the VA's ability to attract high quality health professionals. For example, a California VA hospital has been without a chief of radiology for over a year because the radiology department lacks modern equipment. In the face of budget shortfalls, the VA's ability to serve veterans is unfortunately compromised.

Eligibility

One in three of the nation's 27 million veterans are eligible to receive care on demand from the VA. Such patients, referred to as "Category A," have service-connected disabilities or meet an income-based means test. Category A veterans account for 96 percent of the patients treated in the VA system. Category B and C patients, those whose medical conditions were not caused by wartime service or whose incomes exceed $16,467 for B veterans and $21,955 for C veterans, are considered discretionary care and are eligible for care in the VA system on an availability basis. When fiscal constraints became over-burdening in 1989, the VA Central Office adopted an official policy to eliminate all B and C care.

The Challenge of AIDS

In response to the challenge of AIDS, the VA has been a major contributor in the national effort to treat and control this fatal disease. The VA has consistently treated approximately seven percent of all the nation's AIDS cases. In 1988 the VA's caseload totaled approximately 7,000. For FY-1991, the VA expects to treat over 4,000 new inpatients, 3,000 readmissions from previous years, and 7,500 outpatients. The total cost for AIDS treatment is conservatively estimated at $220 million. The FY-1990 budget authorization of $32 million for AIDS care did not meet the real costs involved. The VA should be provided with additional funds to meet the substantial costs of AIDS care.

Staffing

Demand for care in the VA has grown universally. In FY-1989, the VA treated over 1 million inpatients and conducted over 21 million outpatient visits. An FTEE level of nearly 195,000 was authorized to meet this work level. By the middle of 1989 fiscal year, the FTEE level had slipped to 191,000, due to budget shortfalls. By the end of the year, further reduction in staff occurred. For example, a survey conducted by the National Association of VA Chiefs of Psychiatry revealed that one out of every five psychiatric positions was vacant.

The VA currently faces great challenges in meeting the system's need for nurses. A recent study by the Office of Personnel Management showed that VA nurses have one of the highest attrition rates in the federal government. While the VA has the authority to set special salary rates for nurses, necessary funding also needs to be provided for salary flexibility and locality adjustments in order to compete for RNs and LPNs.

For dentistry, data indicates that the pool of active dentists and dental school graduates will continue to decline into the next century. The VA will face increasingly fierce competition in recruiting well-trained dentists who are able to provide the challenging type of dental care needed by many of the VA's medically compromised patients.

With proper funding, the VA health professional scholarship program could also play an important role in manpower recruitment. In exchange for tuition assistance, health professionals, including nurses, physicians, and dentists would make a commitment to work in the VA upon graduation.

Personnel Costs

Delivery of medical care is extremely labor-intensive as well as costly. At the VA, personnel and payroll related expenses comprise nearly sixty percent fixed operating expenses. In recent years, labor costs, including salaries and fringe benefits, have risen dramatically, further undercutting the VA's ability to keep pace. The only solution has been to meet the increased personnel costs by borrowing from other discretionary medical care accounts, such as equipment and maintenance. The balance of the overall system has suffered as a result.

When Members of Congress overwhelmingly approved legislation elevating the VA to a cabinet-level department, they demonstrated a deep commitment to the nation's veterans. The VA's new level of authority must be supported by tangible resources in order to ensure that veterans may continue to receive quality health-care.

Education and Training

The VA not only serves as a provider of high quality medical care, it also plays an important role in the education and training of health-care professionals. Beginning after World War II, America's academic health institutions and VA medical facilities established official relationships, known as "affiliation agreements." The affiliations foster an academic environment within the system by bringing faculty, residents, and students to the VA to deliver health care, learn, and conduct research. Through affiliation agreements, veterans receive care from health professionals of outstanding caliber. The affiliation agreements demonstrate an excellent example of successful, symbiotic public-private partnerships.

Recommendation for FY-1991

For FY-1991, the Friends of the VA recommend a medical care appropriation of $13.44 billion. The total recommendation can be separated into two groups, maintaining basic services and authorizing enhancements allowing the VA to adapt to the changing health-care needs of veterans.

Due to severe under-funding, the FY-1991 budget for veterans' medical care cannot be based on the final FY-1990 appropriation. A current services level of $12.1 billion is used by the Friends of the VA because it accounts for funding shortfalls in FY-1990 as well as previous years. Most notably, $12.1 billion includes sums necessary to restore in part equipment and maintenance backlogs, miscalculated payroll expenses, and inflation and uncontrollable cost adjustments.

The Friends of the VA recommended funding levels would enable the VA to meet adequately fixed personnel costs as well as begin to restore programs damaged by cost-shifting. Implementation of the programs listed as "enhancements" will help meet the future needs of veterans.

Recommendation for FY-1991

FY-1990 Current Services	**$12,094,200**
FY-1991 Payroll Related Increases	405,000
Inflation	210,000
Facility Activations & Investment	146,900
AIDS and Property Rental	63,500
FY-1991 Current Services	**$12,919,600**
FY-1991 Enhancements	
Extended Care Program	169,000
Outpatient Workload Increase	165,000
Postgraduate Inservice Training	10,000
Geriatric Training Enhancement	1,500
Equipment	100,000
Decentralized Hospital Computer Program	25,000
Prosthetics and Sensory Aids	4,000
Physician and Dental Pay	50,000
Total Enhancements	524,500
TOTAL FY-1991 RECOMMENDATION	$13,444,100

Preparing for the Future

Important demographic shifts have changed and will continue to effect the needs of the veteran population. Thus far, these challenges have not been addressed properly by the VA health care budget. Data shows two important trends. First, the number of aged veterans is growing rapidly. Despite projections that in ten years 3.8 million veterans will be over the age of 75, the VA currently has only 30,000 nursing home beds. Second, the veteran population is moving southward. The veteran population's shift has led to increased patient loads and unmet demand in certain parts of the country. In other areas, facilities have reduced the number of available beds in response to staff shortages. The system is clearly out of balance.

The Friends of the VA recommend certain program enhancements to help VHSRA adapt to the demands it will face as we approach the year 2000 and to meet other areas of critical need. Program enhancements include:

1. Extended Care Programs This comprehensive program emphasizes long-term, non-institutional forms of care that care cost efficient and maximize veterans' independence. The extended care program would increase and implement the following specific programs:

   - Hospital-Based Home Care to facilitate early discharge of chronically ill veterans, allowing them to return to their own homes;

   - Adult Day Health Care, providing a supportive environment with medical rehabilitative, social, recreational, and health education services to veterans during normal working hours;

   - Geriatric Evaluation Units to analyze and accommodate the total needs of elderly patients who have multiple medical problems;

   - Geriatric Research, Education, and Clinical Centers, designed as centers of excellence to advance and integrate into the VA system geriatric and gerontological research, education, and clinical achievements;

   - Nursing Home Census addressing the need to expand the availability of more institutional, as well as non-institutional, long-term care.

2. Expand Outpatient Care In recent years, health care delivery has adapted to include greater use of the outpatient setting. The VA has also begun to focus on this less expensive, effective method of treatment. The Friends of the VA recommend funding of $165 million to accommodate the 23.8 million outpatient visits expected in the VA during FY-1991.

3. Equipment Backlog Past years of under-funding have left the VA with an estimated $1 billion backlog for replacing equipment. The portion of the FY-1989 supplemental funds used for this purpose did not relieve the backlog. An additional $100 million over the amount included in the Friends of the VA general, annualized FY-1991 costs would help further reduce the equipment backlog.

4. Physician and Dental Pay Discrepancies between VA salaries and salaries offered in academia or private practice have frustrated the VA's ability to compete for full-time physicians and dentists. The VA has been forced to rely on expensive medical specialty contracts to offer a full compliment the necessary services. Current types and levels of bonus and specialty pay do not adequately reward long-term service. The Friends of the VA request an additional $50 million to adjust physician and dentist specialty pay. Such funding would make the VA more competitive in recruiting and retaining high quality professional health care providers.

The Friends of the VA recommendation will ensure that the VA will continue to provide quality medical care. In addition, our recommendation will restore stability in VHSRA's medical care program. Another vital part of VHSRA, the medical and prosthetic research program, also requires increased support.

HEALTH RESEARCH

A Record of Success

The quality of care provided to veterans in VA medical centers around the country is significantly enhanced by the presence of medical, rehabilitation, and health services research programs. These programs attract to the VA distinguished health-care professionals who engage in research activities while providing outstanding medical care to veterans. Research performed ... the VA has led to outstanding improvements in the treatment of life-threatening and disabling diseases and conditions, and has resulted in significant health-care cost savings:

- Prevention of Circulatory and Vascular Diseases The VA is recognized as a pioneer in the development of anti-hypertension drugs, a major factor in the significant decrease in mortality rates for heart disease and stroke between 1968 and 1978. During this period, the number of deaths from heart disease per 100,000 Americans decreased by 10 percent (approximately 95,000 lives spared per year); deaths from stroke declined similarly by 25 percent (65,000 lives spared per year).

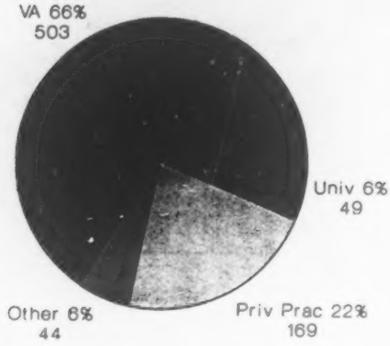
- Treatment of Enlargement of the Prostate A VA-sponsored study of veterans with prostate enlargement suggests that a sizeable number can be treated without surgery. Medical follow-up costs are approximately $1,000, compared to costs of approximately $6,500 for surgical procedures. Greater use of non-surgical treatment as recommended by the study can yield the VA savings of approximately $29 million per year and spare many veterans the discomforts and risks of surgery.

- Detoxification Treatment for Alcoholics Over 200,00 veterans suffer from alcohol dependence. A VA-sponsored study has determined that for those who require detoxification, outpatient treatment is as effective as inpatient treatment and costs nearly 90 percent less. Increased use of outpatient treatment for the 52,000 veterans provided such therapy each year will yield annual cost savings of approximately $17 million for the VA alone.

- Geriatrics Evaluation Units Geriatrics evaluation units (GEUs) are designed to improve hospital care for frail, elderly patients. A VA-sponsored study showed that veterans treated in GEUs to have substantially lower mortality rates and fewer discharges to nursing homes compared to those given standard care. Based on these findings, the VA has established 85 geriatric evaluation units across the country, Use of these units should reduce the number of nursing home admissions by 200,000 per year.

The VA research program's success can also be measured by the effectiveness of its training programs. The VA Career Development program provides grants to support the training of future investigators -- a critically important effort given documented personnel shortages in some areas of health research. More importantly, the program helps train researchers who will remain in the VA system. As illustrated by the graph below, two-thirds of career development awardees trained since 1980 continue to serve in the VA, making the program an excellent tool for recruiting high quality physicians who are dedicated to the VA. This trend has been fairly constant in past years, despite the fact that VA salaries are less than competitive.

Career Development Status
Awardees Since 1980



Location as of Spring 1989

Current Efforts to Improve the Health of Veterans

The VA research program continues to focus primarily on the diseases and disabilities that most commonly afflict veterans. For example:

- Approximately 25 percent of patients seen in the VA are principally diagnosed with mental disorders. A recent study by a VA-supported investigator showed a link between changes in brain chemicals and psychological stress. These findings may improve treatment of extreme mental conditions, including post traumatic stress disorder.

- Diseases of the circulatory system are the principle diagnosis for almost 20 percent of VA patients. VA studies are underway to examine normal cardiac function and the changes which occur during heart disease. Other VA investigators are studying circulation and testing new drugs to control high blood pressure. Such studies show promise for developing new treatments for heart failure.

- Over ten percent of veterans seen by the VA are afflicted with cancer. Researchers have discovered important information that may lead to safer and better use of a promising new drug for treating liver cancer. VA researchers continue to conduct studies to determine appropriate doses of this medication to treat other types of cancer.

- Diabetes is one of the leading causes of blindness, kidney disease, amputations, heart disease, and stroke in veterans. Through a VA-sponsored project, an implantable computer-controlled, programmable insulin pump was developed. This state-of-the-art pump mimics a human pancreas and has the potential to provide dramatically better control of blood sugar, helping to reverse or slow the complications resulting from diabetes.

Other health problems being studied by the VA that affect many veterans include AIDS; diseases of the immune system such as rheumatoid arthritis, multiple sclerosis, and systemic lupus erythematosus; medical needs of the elderly; Alzheimer's disease and other forms of dementia; crippling spinal cord injury; kidney disease and acute renal failure requiring dialysis; drug and alcohol dependence; and digestive diseases and liver disease.

Adequately funded, these research activities hold enormous potential for improving the health of all Americans, as well as reducing health-care costs.

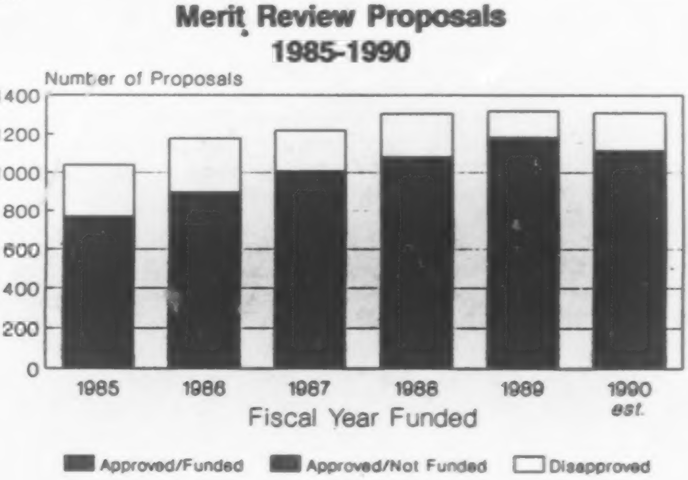
Recent Funding Constraints

Funding levels for VA research have fluctuated dramatically in recent years. This instability has led many VA health care professionals to consider careers outside the VA. This distressing trend has resulted in lost opportunities to pursue health-related research that can lead to important medical discoveries and improved care. If the level of effort remains below that in 1985, the VA research program will be unable to sustain its record of success:

- In 1985, the VA funded 722 merit review awards. The VA projects that only 539 will be funded this year.

- The percentage of meritorious projects actually funded has dropped dramatically -- from 80 percent in 1985 to a projected level of 45 percent for the current fiscal year.

As depicted graphically below, VA funding has been unable to keep pace with medical research opportunities.



It is important to recognize that unfunded grants translate into lost opportunities -- potentially, the loss of discoveries that could lead to dramatic improvements in medical care. Meritorious projects that the VA will be unable to fund this year include studies focussed on: arthritis in the elderly, post traumatic stress disorder, diabetes, Parkinson's Disease, prostate cancer, and epilepsy.

Recommendation for FY 1991

For FY-1990, the VA research program received an increase of less than 2 percent -- a level of growth below the inflation rate, forcing the VA to curtail its activities. The Friends of the VA believe it is vital to restore and maintain stable funding for the research program. Adequate funding will allow research accomplishments to continue to improve the quality of care provided to veterans. In order to achieve this, we recommend a total FY-1991 budget of $268 million: $252.5 million to rejuvenate the program to the level of effort achieved in 1985 and $15.5 million to allow for special initiatives to address health problems that are particularly acute among the veteran population.

HEALTH RESEARCH
(in millions)

	FY-1990*	FY-1991 Recommendation
Medical Research	$179.8	$219.0
Rehabilitation Research	$ 21.6	$ 23.2
Health Services Research	$ 9.2	$ 9.3
CDC-Agent Orange Study	$ 2.0	$ 1.0
BASE-LINE RECOMMENDATION		$252.5
Special Initiatives		$ 15.5
TOTAL FY-1991 RECOMMENDATION	$212.6	$268.0

* Does not include transfers

It is important to recognize that a budget of $268 million will simply continue moderate growth in the activities of the rehabilitation and health services research programs and restore the FY-1985 level of effort for the medical research program. It would:

- provide support for 1,840 projects -- the same number funded in FY-1985. Unfortunately, a significant percentage of meritorious research grant applications would continue to go unfunded under this recommended budget.
- Fund twenty-six cooperative studies -- the same number supported in FY-1985.
- provide for 240 career development awards -- thirteen more than were funded in 1985.

We recommend an additional $15.5 million to fund several special initiatives that hold great promise for insuring that some of the most detrimental conditions suffered by veterans are addressed. This additional funding would provide for an expansion of AIDS research; a nerve regeneration center; alternatives to nursing home care; medical care for the homeless; a multi-site trial of VA geriatric evaluation units; and additional projects on schizophrenia and mental illness.

The Friends of VA Medical Care and Health Research believe that an FY-1991 VA research budget of $268 million is necessary to continue moderate growth in rehabilitation and health services research, to revitalize the medical research program, and to provide for a limited number of special projects of particular concern to veterans.

STATEMENT OF HON. PORTER J. GOSS, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

Mr. Chairman, I am deeply concerned about the impending redistricting of the Veterans Administration regional offices. In theory, reorganizing and streamlining bureaucracies is a worthwhile exercise, one that often improves efficiency and efficacy in service delivery. In practice in this case, however, eliminating the 11 VA regional offices would not only be counterproductive to the goals of the VA, but would also seriously jeopardize the quality and availability of service for veterans.

I am specifically concerned about the serious consequences of the reorganization for the State of Florida, which has the fastest growing veterans population in the Nation with the highest incidence of service-connected outpatient health care. In addition to caring for its own citizens, Florida also provides veterans services to a large number of part-time residents, many of whom live in the State during the winter months.

The existing VA regional office in Florida currently handles more cases per worker than any other such office. What will happen to this enormous volume of veterans service needs if that office is suddenly closed in favor of a larger, more impersonal facility in Mississippi (as the proposed reorganization dictates)?

The State of Florida is unique in its veterans' service needs. We are already experiencing a shortage of veterans health-care facilities and resources. We need more support and attention from the VA, not less. Today the State's only direct link to the VA is the existing regional office in Gainesville. Remove that in favor of a facility in another State and you will do a tremendous disservice to Florida's veterans.

Mr. Chairman, our veterans have sacrificed a great deal on behalf of this country. They deserve fair and equitable representation with the government agency dedicated to servicing their needs. The current redistricting proposal would effectively abandon Florida's veterans by eliminating their only direct representation with the VA. I doubt anyone would consider that to be fair and equitable.

Thank you.

STATEMENT OF HON. EARL HUTTO, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

Chairman Cranston, thank you for providing me the opportunity, before this committee, to express my concern over the tremendous challenges faced by Secretary Derwinski and the personnel of his Department of Veterans Affairs, to meet the demands of providing health care to an aging and expanding veterans population. Many of us realize that the Veterans' Administration, as it was formerly known, has played a pioneering role in the development of health services for the aged in the United States.

Additionally, the Department of Veterans Affairs has the responsibility for managing a wide array of Federal programs for more than 27 million veterans and over 47 million of their survivors and dependents, who are potentially eligible for various veterans' benefits and services. Based on this, one might say the services and management of these services, by the Department of Veterans Affairs, touch close to one-third the population of these United States. While the veteran population has been declining, since a peak of 28 million plus in 1980, I realize the cost of many of the programs continues to rise because of inflation adjustments; improved benefits; increased personnel, material, and maintenance of equipment costs; and, the fact that more veterans are using health and burial benefits.

Medical care is provided to our eligible veterans and certain dependents and survivors of veterans in over 172 VA hospitals, 119 nursing homes, 233 outpatient clinics, and 26 domiciliaries, as well as through VA contractual agreements with non-Federal facilities, sharing agreements with Defense Department activities, and under the Civilian Health and Medical program (CHAMPVA).

Currently, 7 regional offices and 27 medical districts, that report to the Washington Central Office, manage these various programs. These same district and regional offices are the ones that directly help me and my staff in the resolution of the myriad of problems surfaced by veterans in my district in the western Panhandle of Florida. For years we have been trying to obtain a hospital to complement the care provided by outpatient clinics and active military medical facilities in the district in order to satisfy the needs of over 25,000 veterans living here.

The proposed budget you are considering reduces the regional offices from seven to four and eliminates the medical district offices. Realizing that these district offices coordinate cooperative efforts, such as long and short term health-care planning for a group of hospitals within a close geographic area and conduct peer review and quality assurance investigations, a great load will be placed on the remaining organization.

These are the reasons why the proposed reorganization of the Veterans Health Services and Research Administration concern me.

I understand that officials of the Department of Veterans Affairs claim that these changes will result in uniform management practices throughout the system, improve communication between Veterans' Affairs headquarters and individual medical facilities, and eliminate the duplication of activities by medical district and regional offices. However, I share the views of the Disabled Veterans National Director for Medical Affairs, David W. Gorman, when he recently stated, "provided the VA's reorganization is a management tool to streamline the administration process, without adversely affecting the delivery of health-care services to veterans, we don't have a problem with it." Neither do I. It is my hope that the input of individual medical facilities in policymaking is not lost as a result of the proposed reorganization.

Mr. Chairman, in your oversight responsibility, I ask that your committee closely monitor the Department of Veterans Affairs implementation of their plan to ensure the interests of veterans' health-care services are safeguarded.

Thank you, Mr. Chairman.

STATEMENT OF HON. TOM LEWIS, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

Mr. Chairman, thank you for the opportunity to testify on the proposed reorganization of the Veterans Health Services and Research Administration. As you know, this is an issue of great concern to both of our States, and indeed most of the States experiencing large increases in their veteran populations.

I am usually a strong supporter of the streamlining of Government organizations, since the ultimate goal is usually to provide better service. However, in my view, this reorganization will not improve services for the majority of our veterans.

In addition, there is a fine line between streamlining and simply centralizing the decision-making process. When this process is centralized, the influence passes from those closest to the problems. This is a dangerous development for our veterans.

Most specifically, I am concerned with the elimination of the office in Gainesville, FL. It is virtually impossible to tell you how many times my staff and I have turned to the regional staff in Gainesville for assistance. By virtue of their location, they are familiar with the particular needs and problems of the 1½ million veterans in Florida, and most often can readily provide a specific answer or solution. I am not convinced the same will be true for Jackson, MS.

Mr. Chairman, with the phenomenal growth of Florida's veteran population, we should be adding resources, not taking them away, especially when one considers the new VA facilities to be built in Palm Beach, Tampa and Gainesville. It makes no sense to add facilities while removing the resources needed to effectively manage them.

To conclude, I believe it would be in the best interests of the large majority of our Nation's veterans if this committee were to revisit this proposed plan to ensure it is really a more efficient method of providing the care so desperately needed by those who so bravely served their country.

STATEMENT OF HON. CONNIE MACK, U.S. SENATOR FROM THE STATE OF FLORIDA

Mr. Chairman, I want to express my concerns regarding the proposed reorganization of the Veterans Health Services and Research Administration.

Florida's veteran population is growing way above projected levels. As of September 30, 1989, Florida's veteran population was estimated at 1.5 million, making Florida the State with the second largest veterans population. Because of this tremendous growth, my efforts for Florida's veterans to receive their fair share of Federal funds are now more important than ever.

I applaud the efforts of the Veterans' Administration to serve the needs of veterans throughout Florida. Funds have been appropriated/authorized for the construction of a new medical center and nursing home in Palm Beach, and the construction of a 290 bed psychiatric center in Gainesville. Efforts like these must continue in Florida so that our commitment to our veterans for quality health and nursing home care will be fulfilled.

With this in mind, I am concerned about the proposed reorganization of the Veterans Health Services and Research Administration, and specifically the elimination of the 27 medical districts around the Nation.

Currently, Florida is served by its district office in Gainesville. With the elimination of the medical districts, and the reorganization of the VA Health Service into four regions, the regional field office for Florida will shift to Jackson, MS.

It is my belief that if this planned reorganization goes into effect, the importance and impact of the medical districts may be lost. The needs of individual States may be compromised as they compete with one another within their respective regions. It is my concern that the ability of states to provide their input for VA spending priorities will vanish. This would be a terrible loss for high growth States such as Florida.

I urge the Veterans' Administration and the Committee on Veterans' Affairs to take into account the importance of the 27 medical districts. If they are abolished under the proposed plan, it is my desire to see that the Veterans' Administration appoint within each State a representative to maintain the vital relationship I have described. I am hopeful, however, that the Secretary will carefully study the reorganization of the regions and the elimination of the medical districts.

STATEMENT OF THE MANUFACTURED HOUSING INSTITUTE

We are pleased to have the opportunity to offer our views on proposals for changes in veterans benefits made by the Department of Veterans Affairs and under consideration by this committee. Our statements are made on behalf of the members of the Manufactured Housing Institute and the National Manufactured Housing Federation.

THE MANUFACTURED HOUSING INSTITUTE

The Manufactured Housing Institute (MHI) is a national trade association representing manufactured home builders and related suppliers of goods and services to the industry and its consumers. MHI manufacturer members produce over 55 percent of the manufactured homes built in the United States.

THE NATIONAL MANUFACTURED HOUSING FEDERATION

The National Manufactured Housing Federation (NMHF or Federation) is a national trade association comprised of 47 State and regional manufactured housing associations. These State and regional associations contain within their memberships over 8,000 retailers and 20,000 developers active in manufactured home sales, service and land development. Ninety percent of all new manufactured homes sold in the United States in 1989 were sold by NMHF-affiliated retailers. NMHF-affiliated developers own and operate over 1.5 million manufactured home sites across the United States.

THE MANUFACTURED HOUSING INDUSTRY

The advantages of mass production spawned the development of factory-built housing over 50 years ago. Today there are several forms of factory-built homes, including modular, panelized, and manufactured homes. Our remarks, concern themselves with the form of factory-built housing known as manufactured homes, formerly known as mobile homes.

Manufactured homes are delivered from the factory in one or more sections. They are completely assembled and require only minimal labor to make them ready for occupancy once delivered to a home site.

Manufactured homes are built to Federal standards prescribed by Congress in the National Manufactured Housing Construction and Safety Standards Act of 1974 (Public Law 93-383). These standards were developed and implemented by the Department of Housing and Urban Development (HUD) in June 1976. As a result of HUD's involvement, these homes are commonly referred to as HUD-code homes.

Since developing the standards, HUD has maintained its surveillance of the manufactured housing industry, primarily through its agent the National Conference of States on Building Codes and Standards.

Innovative technology, improved aesthetics, and a Federal construction code that ensures consistent health and safety standards throughout the U.S. have all played a significant role in making manufactured housing an important part of the permanent housing stock in America.

In the decade of the 1980's, manufactured home builders produced 2.5 million homes, accounting for 14.2 percent of the 17.4 million privately-owned housing construction started during the decade, including manufactured homes. The "1987 American Housing Survey," the most recent of the biannual housing surveys published by the Department of Commerce, Bureau of the Census, indicates that there were 90.9 million full-time occupied housing units at the end of 1987, including manufactured homes. Full-time occupied manufactured homes accounted for 5.3 million, or 5.3 percent, of the total full-time occupied housing units in the U.S. at the end of 1987, according to the survey.

Currently manufactured homes are providing permanent shelter to more than 12 million Americans, most of whom are families of modest means.

THE DEPARTMENT OF VETERANS AFFAIRS MANUFACTURED HOME LOAN GUARANTY PROGRAM

The Department of Veterans Affairs (VA) was first authorized to guarantee loans on manufactured homes by the Veterans' Housing Act of 1970 (Public Law 91-506). The 1970 act provided for termination of the program on July 1, 1975 to give Congress time to evaluate it. The program became permanent with the passage of the Veterans' Housing Act of 1974 (Public Law 93-569), and Congress affirmed its belief that the VA Manufactured Home Loan Guaranty Program was beneficial and provided a good source of affordable housing to veterans.

The program has provided more than 112,000 veterans the opportunity to own their own home from its inception through 1989. For this reason, we believe the program is an important and valuable part of the overall benefits provided to veterans through the various activities carried out by the VA.

Manufactured home loans guaranteed by the VA are eligible for pooling into Government National Mortgage Association (GNMA) mortgage-backed securities. Through GNMA, the VA program provides an important access to loan funds available through institutional investors and others who buy GNMA securities. Access to investors through secondary markets became an increasingly important source of funds for housing finance in the 1980's, a trend that is expected to continue to grow in the 1990's. Even though the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation have legislative authority to operate manufactured home loan personal property programs, at this time, GNMA is the only operational organized secondary market source for publicly traded securities backed by manufactured home personal property loans.

PRESERVATION OF THE MANUFACTURED HOME LOAN GUARANTY PROGRAM

It will come as no surprise to you that we oppose the elimination of the VA's Manufactured Home Loan Guaranty Program authorized under 38 U.S.C. 1812. At the same time, we share the concerns of the VA over losses sustained by the program. However, instead of eliminating this veterans' benefit program, we would respectfully recommend that changes be made to the program that will make it more fiscally sound. This was the approach taken by this committee in recommending the creation of a VA Guaranty and Indemnity Fund for conventionally-built homes. Title III of the Veterans' Benefits Amendments of 1989 (Public Law 101-237) created the fund that will hopefully improve the VA's site-built home loan guaranty program. The approach to improving the manufactured home program may be different, but no less important for those veterans whose affordable housing choice stops with manufactured housing.

HUD has adopted the approach of fixing their FHA title I program instead of eliminating it. Last year they requested suggestions for improving the program from the manufactured housing industry, FHA title I approved lenders and the public at large. They have received a number of suggestions, including a detailed proposal drafted by the National Manufactured Housing Finance Association and supported by MHI and the Federation. HUD has reaffirmed its commitment to preserving an FHA title I program for manufactured home loans that will continue to provide a source of affordable housing while protecting the public interest and taxpayer's dollars. We would respectfully submit that this approach would better serve veterans than eliminating the program.

The VA Inspector General's Report

The recommendation to repeal the VA's authority to guarantee loans secured by personal property manufactured homes was made by the Office of the Inspector General (IG) of the Department of Veterans Affairs in a report dated September 7, 1989. The IG cited the following reasons for his recommendation:

—High foreclosure rates and heavy losses in the program;

—Inherent weaknesses in the program, including a lack of borrowers' equity in the homes and a high participation rate by marginal borrowers;

—Low volume of loans in the program;

—A disproportionate use of the program by active duty military personnel;

—Veterans will still be able to obtain VA-guaranteed loans under 38 U.S.C. 1810 on permanently-sited manufactured homes treated as real estate under State law.

We agree with the VA that something must be done to lower the foreclosure rates and losses in the program. We disagree, however, that elimination of the program is the solution. We would prefer to see changes made to the program that will eliminate the causes of the high foreclosure rates and losses; changes that will preserve for veterans a freedom of choice to use the program, providing that eligible veteran borrowers represent a reasonable credit risk to the lending institution making the loan and the VA as guarantor.

The following paragraphs address the five major issues listed above that were raised by the IG as justification for elimination of the program. They also suggest solutions for these problem areas; solutions that we would urge this committee and the Department of Veterans Affairs to consider seriously, perhaps along with some of their own, before they kill a program that will leave many low- and moderate-income veterans with no substitute.

Foreclosure Rates on VA-Guaranteed Manufactured Home Loans

The VA IG report cites high foreclosure rates on VA-guaranteed manufactured home loans. He says that 27 percent of all loans made under the program have ended in foreclosure while only 5 percent of VA-guaranteed site-built home loans have ended in foreclosure. While we agree that a 27 percent foreclosure rate is unacceptable, the comparison of site-built foreclosure rates to manufactured home foreclosure rates is not a valid one.

While site-built home buyers cover a broad spectrum of income levels, manufactured home buyers are, in general, lower-income borrowers. If one compares the foreclosure rates on loans for comparably-priced site-built homes and manufactured homes the contrast is not nearly as stark.

COMPARISON OF TERMINATION RATES OF VA-GUARANTEED LOANS—HOMES PRICED UNDER $35,000

Fiscal year loan made	Site-built homes (percent)	Manufactured homes (percent)
1979	8.5	15.2
1980	13.9	17.3
1981	17.4	23.3
1982	14.2	20.1
1983	3.7	7.3

Source: VA Staff Report, Program Review, "Manufactured Home Loan Program," Loan Guaranty Service, March 10, 1986.

Foreclosure rates on manufactured home loans are still higher, but the ratio is much closer than when the site-built home loan foreclosure rate includes homes in all price ranges. High foreclosure rates are not a symptom of buying manufactured homes, they are an unfortunate fact of low-income borrowers.

Recommendation One:

Review requirements on income levels and debt-to-income ratios in the VA loan guaranty program and vigorously apply sanctions to program participants who fail to follow these guidelines.

This will have the adverse effect of denying some low-income veteran borrowers the benefits of the program, but it will eliminate the marginal borrowers who are most likely to default.

The VA moved in this direction on October 1, 1986 and we believe the lower volume in the manufactured home program recently is, in part, a direct result of these tighter credit underwriting standards and that there has been a corresponding decline in foreclosure rates on manufactured home loans. However, if the VA has determined that marginally credit worthy borrowers are slipping through the system, then another look at credit underwriting standards and their strict application by program participants would appear a prudent move.

HIGH PARTICIPATION RATE BY MARGINAL BORROWERS

One of the purposes of Congress in creating the manufactured home loan guaranty program was to provide a source of affordable housing to veterans that was not being provided under the VA's original home loan guaranty program (38 U.S.C. 1810). Clearly, affordable is a relative term, but in this context it means, as a practical matter, lower-priced housing for borrowers whose incomes do not permit them to afford higher-priced housing. Low-income borrowers are almost by definition marginal borrowers, although that does not imply that all are poor credit risks.

Recommendation one above suggests that the VA adopt and vigorously enforce income and debt level credit underwriting standards that will filter out the most marginal borrowers who are poor credit risks. It also suggests that the VA levy sanctions against program participants who do not diligently and effectively apply the VA's standards.

If there are sound fiscal policies in place, and we think the VA has some in place already, they must be communicated clearly to the administrative personnel who are charged with carrying them out. There must be a clear and readily accessible line of communication so that program policies are administered fairly and consistently on a nationwide basis.

PROGRAM ADMINISTRATION

The IG notes in his report that there are problems for the VA in administering the manufactured home loan guaranty program because of its low volume. Administration of the program requires special training of VA staff because manufactured home loans are made under a different set of regulations and require a different set of procedures for loan origination. The IG says that allocation of a significant staff to the program, given the program's low volume, would not be cost effective.

Recommendation Two:

Centralize manufactured home loan processing at the headquarters office of the VA in Washington, DC or in three regional offices (east, central and vest) as close as possible to where the volume centers for the program are located.

Centralization of processing will lower staff requirements and facilitate consistency in the administration of program regulations and guidelines. One of the major administrative problems cited by lenders who use the VA program is the inconsistency between various VA field offices in interpreting and administering VA manufactured home loan guidelines. Centralized processing would help to eliminate this inconsistency.

Centralized processing also appears to be a reasonable response to the regionalized nature of manufactured home sales. There is geographic concentration in demand for manufactured housing in the southeast and southwestern areas of the country, partly because of the demographics of the population in those areas and partly because these parts of the country tend to have more rural areas, where demand for manufactured housing is greatest. The location of military installations probably adds to the geographic concentration in the VA manufactured home program.

The IG noted that in spite of high foreclosure rates in the program, there had never been any action taken to remove a manufactured home lender's authority to originate loans because of poor underwriting performance. An example was cited of one lender that made over 5,000 loans over a 3 year period and had a foreclosure rate that was twice the national average. Yet no action was taken by the VA to remove that lender's authority to originate loans. Recommendation three would help to spot these kinds of problems faster and take more expedient action. Specific guidance to administrative personnel on what constitutes a program violation and the appropriate corrective action is critical to preventing these kinds of situations.

Recommendation Three:

Develop an administrative handbook that indicates as simply as possible the rights and responsibilities of all parties involved in the transaction: the lender, the VA, the retailer and the borrower.

This would help to eliminate gray areas into which program violations might fall and would give administrative staff the comfort they need to apply sanctions without fear of reprisal. At the same time it will give program participants clear guidelines on the kind of performance that is expected from them.

LEVEL OF EQUITY OF DEFAULTING MANUFACTURED HOME BORROWERS

In the loans examined by the VA IG, it was found that defaulting borrowers', in general, had no equity in their homes. This is a problem not unique to the VA program. Manufactured home lenders too often face the same problem when a borrower defaults. It is a paradox that some of the same things that make a manufactured home affordable lose their value when the home is resold after a borrower default. This is particularly true if the home must be moved from its site after the default.

Manufactured homes are most often sold without land. The buyer usually rents space in a manufactured home rental community or land from a private owner. Transactions where the home and land both secure the loan are not in the majority for manufactured home borrowers. The ability to buy the home without having to also purchase the land is a part of what makes the transaction affordable, but it also removes from the transaction the old real estate rule of value—location-location-location. Even if the home is in a desirable rental community, the owner of the community may require its removal if the home is unoccupied for a period of time.

The necessity to move the home for resale may be caused by several factors. As mentioned above, it may be a rule of the community that unoccupied homes may not remain in the community, even if the lender is willing to pay the lot rent. A second and probably more prevalent reason is that lenders have neither expertise nor resources to resell repossessed manufactured homes. They have no place to store and display them, or crew to restore them and show them to potential customers. They must rely on the retailer network for restoration and resale. This means it is necessary to move the home to a retailer's sales lot for refurbishing and resale. Whatever location value the home may have had in its community is lost. The situation is further exacerbated by the fact that there is a cost to move the home from a community to a retailer's lot and again to a community when a new buyer is found. There are also costs to refurbish the home to make it ready for resale, which may range from minor painting and repairs to major repairs and replacement of appliances and other items originally purchased and financed with the home.

Recommendation Four:

Amend VA regulations or guidelines to include incentives that will facilitate the resale of repossessed manufactured homes at their original site.

To the extent that a repossessed home can be sold in place, a number of items that add to the default loss can be eliminated, not the least of which is transportation, that must be paid for twice—once to pick up the home and once to deliver it to the new buyer's home site.

Furniture is sometimes included with a manufactured home and allowed in the amount to be financed. This is a practice that developed in the industry to enhance the affordability of its homes. Including furniture and other accessories with the home relieves the borrower of the burden of purchasing them later, often with an additional extension of credit. Unfortunately, some of these accessories do not recapture much of their value when the home is resold. Furniture could be removed as an item that is allowed in the amount to be financed. HUD recently amended its regulations to make this exclusion in their FHA title I program. HUD has developed a list of items that are not allowed to be in the calculation of the amount of financing allowed in a manufactured home loan insured under the FHA title I program. The VA also has a list of such items. It would be useful for both programs to adopt similar guidelines. This approach would not only exclude items that may have little value on resale, but would also eliminate differences in the two programs that make their administration difficult for lenders who participate in both programs. Making the HUD and VA programs as similar as is practical would have the added advantage of attracting more lenders by eliminating time-consuming administrative differences between the two programs.

Recommendation Five:

Amend VA regulations on items that are allowed to be financed with the purchase price of the home to include only those items that will make the home a safe and sanitary residence for the veteran buyer.

LOW VOLUME OF LOANS IN THE PROGRAM

Loan volume in the VA Manufactured Home Loan Guaranty Program has dropped dramatically over the last several years, and in fact has been declining steadily after reaching a peak in 1983. Volume decline has been most dramatic since 1986. Loan volume since 1986 has been as follows:

Calendar year	*Number of loans*
1986	5,851
1987	4,259
1988	1,674
1989	643

On October 1, 1986 the VA imposed higher income limits in its loan guaranty programs and implemented a debt-to-income ratio of 41 percent. On February 1, 1988 a congressionally mandated 5 percent down payment requirement was imposed on VA-guaranteed loans secured by manufactured homes under 38 U.S.C. 1812. We believe that these two changes have had a major impact on lowering the number of manufactured home loans guaranteed by the VA and has reduced foreclosures and losses in the program. It is not unreasonable to believe that the underwriting changes and down payment requirement have eliminated many of the marginal borrowers that the IG cites as causes of high default rates and losses in the program.

Recommendation Six:

Amend eligibility requirements for VA home loan guaranty benefits to include members of the U.S. National Guard and active reservists.

These so-called weekend warriors should not be denied service-connected benefits because they have chosen to serve their country in a different way. Not only are the men and women who make up military reserve units an important asset in defending the freedom of Americans, they are frequently called upon to respond with help to local citizens in an area where there has been a natural disaster or some other emergency.

Members of the U.S. National Guard and reservists are likely to be reasonable risks for the home loan guaranty program because they are people who are members of the civilian work force as well as members of the military. They are likely to have established careers and good credit records. They would provide a source of volume for the program without adding greater risk of foreclosures and losses.

DISPROPORTIONATE USE OF THE PROGRAM BY ACTIVE MILITARY

The VA IG says that a high percentage of manufactured home loans guaranteed by the VA in recent years have been to active duty military personnel. These borrowers, says the IG, have a higher foreclosure rate than veteran borrowers.

We believe that the higher foreclosure rate for active duty personnel is due in large measure to the policies of the Department of Defense (DOD) when transferring lower-ranking active duty personnel. In most instances a notification of an impending change of duty station allows insufficient time for active duty borrowers to sell their homes, and the DOD has been unwilling to make sufficient transfer expense allowances to allow lower-ranking enlisted personnel to move their homes.

Recommendation Seven:

Urge the DOD to cooperate with VA when transferring personnel with outstanding VA-guaranteed loans. Base Housing Officers should notify the VA and the lender as soon as it is known that these personnel are to be transferred.

With this advance notice the VA and the lender may begin earlier efforts to help effect an assumption of the borrowers liability with another borrower in the area. Base Housing Officers may even be able to lend support to finding another active duty borrower in search of off-base housing.

VA-GUARANTEED LOANS ON MANUFACTURED HOMES UNDER THE VA'S SITE-BUILT HOME LOAN GUARANTY PROGRAM

A part of the IG's rationale for elimination of the manufactured home loan guaranty program (38 U.S.C. 1812) is that veterans will still be able to get VA-guaranteed loans secured by manufactured homes through the VA's conventional home loan guaranty program (38 U.S.C. 1810) if the manufactured home is permanently sited and treated as real estate under State law. While this statement is technically true, the transition from one program to the other is, for the most part, not possible in today's marketplace.

A large part of the problem is rooted in the affordability factor. The manufactured housing industry produces a wide range of housing products from inexpensive, no frills single- and multisection homes, to large, well-appointed multisection homes suitable for placement on permanent foundations (or even basements) in a conventional site-built-type subdivision setting. The least expensive and therefore the most affordable homes are generally sold without land because that is what the customer wants. These homes are financed as personal property and therefore not eligible under the VA's conventional program. These are the homes that are still the industry's main product and are demanded by low- and moderate-income buyers because of their affordability. To eliminate the program that allows low- and moderate-income veterans the ability to purchase these homes by using their hard-earned VA benefit is essentially to deny them the benefit of home ownership altogether.

We are very supportive of the VA's policy of accepting permanently sited manufactured homes treated as real estate in their conventional home loan guaranty program. But we disagree strongly that that program will be able to fill the void that will be created if the manufactured home loan guaranty program is eliminated.

SUMMARY AND CONCLUSION

We urge the committee and the VA to preserve the VA Manufactured Home Loan Guaranty Program by finding ways to lower the foreclosure rate. We believe veterans deserve the freedom of choice that this program brings. We have made a number of suggestions that we believe represent a good starting point for improving and preserving the program. We would welcome the opportunity to work with the VA home loan guaranty staff and the committee staff in refining our recommendations and finding others that will improve the program.

STATEMENT OF THE MORTGAGE BANKERS ASSOCIATION OF AMERICA

MBA appreciates the opportunity to submit this statement for the record for the hearing on the administration's proposed Fiscal Year (FY) 1991 budget for the Department of Veterans Affairs (DVA) home loan guaranty program. Also, MBA will comment on several provisions of the "Veterans' Benefits Amendments Act of 1989," Public Law 101-237, passed by Congress in late 1989, which created the Guaranty and Indemnity Fund (GIF), including the increased loan limits and the funding fee paid by veterans when a loan is refinanced. Unfortunately, there also are several provisions of the "Veterans' Home Loan Program Improvements and Property Rehabilitation Act of 1987," Public Law 100-198, signed into law on December 21, 1987, which are yet to be implemented. These include the new appraisal and mandatory underwriting on assumptions procedures.

MBA wishes to express its appreciation for the consideration given in 1989 by the Senate Veterans' Affairs Committee to the concerns expressed by the mortgage banking industry about the home loan guaranty program and for the provision in Public Law 101-237 amending the foreclosure claim payment statute to prohibit the inclusion of the Government's cost of funds in the no-bid formula.

FISCAL YEAR 1991 VA BUDGET

In the budget for FY 1991 that the administration submitted to Congress, there are proposals which would: (1) include the DVA's average loss per property in the no-bid formula; (2) require the veteran to make a downpayment on most loans; and (3) increase the funding fee paid by veterans for originating a loan. The second and third proposals would change the new GIF, which was enacted only 2 months ago and covers loans originated within the last 52 days.

Congress enacted a new financing mechanism when it created the GIF, which requires the Federal Government to contribute to the GIF 0.75 percent of the loan amount, ratably over 3 years, when the loan is originated. This amount represents the government's share of the risk of loss for the loan. This differs from the funding procedure for the Loan Guaranty Revolving Fund, which covers all loans originated before 1990, where the Government annually appropriates funds based on its estimated losses for the upcoming fiscal year.

Until the end of 1989, the veteran paid a funding fee, which was 1 percent of the loan amount, when a mortgage was originated. Public Law 101-237 established the amount of the funding fee on a sliding scale, based on the borrower's downpayment. In addition, with certain exceptions, the veteran is released from liability to the

DVA in cases where the secured property is foreclosed and the DVA is required to make good on the guaranty.

The GIF has only been in effect for less than 2 months; the administration proposes in its FY 1991 budget to make drastic changes by cutting off the DVA's financial support. MBA believes it is grossly inappropriate not to give the GIF the opportunity to operate as intended by Congress.

DVA'S AVERAGE LOSS PER PROPERTY

MBA adamantly opposes the budget proposal to change the no-bid formula by deducting from the net value of the foreclosed property the DVA's average loss per property. No-bids would increase nearly 100 percent, from 18 percent to 35 percent.

The lender bears a significant risk when making a VA home loan because of the possibility of a no-bid. The no-bid formula is used to determine whether the VA or the lender will acquire a foreclosed property. When the lender acquires the property, there are often significant losses. Since the institution of the no-bid formula in the early 1980s, lenders have suffered no-bid losses of hundreds of millions of dollars.

The DVA would treat all properties, regardless of geographic location and the state of the local economy, as if they were the same. It is not reasonable to treat all properties alike. A loss on one property has no relation to the value of another. A property in one area may have appreciated while one in another area may have depreciated.

The budget states that the proposal to include the DVA's average loss would increase risk-sharing with lenders. It is well known that lenders' share of losses on VA loans has increased from 2.9 percent in 1981 to 18 percent in 1989. Clearly, the DVA is aware of the position of mortgage lenders on the no-bid issue and of the fact that irreversible damage would be done to the VA home loan guaranty program if the VA home loan rules were changed to increase the number of foreclosures where the lender must acquire and dispose of the property.

First, it would be unconscionable to include this additional cost in the formula and apply it to existing loans. When these loans were underwritten, this risk was nonexistent and could not be taken into consideration when making the decision whether or not to originate the loan.

Second, lender participation in the program would be greatly reduced, if not completely eliminated. This DVA proposal runs directly counter to the spirit of the 1989 legislation, which increased the loan amount the VA is permitted to guarantee from $144,000 to $184,000. Congress intended to expand the availability of VA-guaranteed loans to encourage veteran homeownership in housing markets where VA loans had become impossible to originate. The 1989 law also prohibited the DVA from including the Government's cost of funds in the formula, again stating the Congress' intent that lenders should be encouraged, not discouraged, from participating in the program.

The DVA continues to propose shifting its costs to the private sector rather than pursuing other means of reducing its costs. In a December 1989 report, "Increased Use of Alternatives to Foreclosure Could Reduce VA's Losses," to House VA Committee Chairman G.V. (Sonny) Montgomery (D-MS), the U.S. General Accounting Office (GAO) made recommendations to the DVA on reducing home loan foreclosure losses.

GAO pointed out that means other than foreclosure were seldom used to terminate defaulted loans. Foreclosure, usually the most expensive method, was chosen in 97 percent of the cases reviewed by GAO. Using alternatives would have saved between $42 million and $94 million in FY 1987. GAO recommended that a cost analysis be used on a case-by-case basis to identify the costs for each loan termination alternative and that the least costly alternative be pursued.

The alternatives that are discussed by GAO include compromise agreements, voluntary conveyances, and refundings. A compromise agreement, useful when the loan balance exceeds the property value, would allow the veteran to sell the house and use the proceeds and financial assistance (a partial claim) from the DVA for the deficit amount to pay off the loan. The Federal Housing Administration (FHA) has adopted a mechanism similar to this and implemented it in a pilot program. Not only would the DVA avoid all of the costs associated with foreclosure, acquisition and disposition, but the veteran's liability to the DVA would be less under a compromise agreement.

A voluntary conveyance, or transfer of the deed, by the veteran to the DVA is advantageous to both the DVA and the veteran, as well. The veteran avoids having a foreclosure on his/her credit rating and may be released from liability to the

DVA. The DVA saves foreclosure costs and time because there is no redemption period. Also, the loan is terminated more quickly and the property can be resold sooner.

Refunding, which entails the DVA paying off the lender and establishing a repayment plan for the veteran, allows a veteran to retain the property and would be more cost effective for the DVA in some cases. Refunding is appropriate when the lender cannot refinance the loan and the veteran has sufficient income to make lower monthly payments. It is estimated that 50 percent of refunded loans are reinstated, thereby eliminating half of potential foreclosure cases. According to GAO, the average loss on a foreclosed loan in FY 1987 was $15,817, while the average additional loss on a foreclosed refunded loan was $2,394. Consequently, a single successful refunding saves $15,817, enough to offset six unsuccessful attempts.

MBA strongly opposes further shifts of DVA losses to lenders and believes the DVA should reduce its costs by increasing its use of alternatives to foreclosure.

FUNDING FEE

The administration proposes to increase the fee for veterans to 1.75 percent for all loans, regardless of whether or not there is a downpayment. The funding fee, which became effective January 1, 1990, is 1.25 percent for no downpayment loans, reduced to 0.75 percent and 0.50 percent for 5 and 10 percent downpayment loans, respectively. The proposal also would eliminate the Federal government's 0.75 percent contribution to the GIF at the time the loan is originated. Therefore, the increase in the funding fee would shift the Government's financial risk to veteran borrowers.

The new Guaranty and Indemnity Fund should be given an opportunity to work before major changes are made in the fees. It is unbelievable that the administration would propose such major changes to a program that is less that 2 months old. In addition, such a sharp increase would radically alter the nature and benefit of the VA home loan guaranty program. It would convert the VA home loan guaranty entitlement to a user fee paid credit program.

MANDATORY DOWNPAYMENT

Veterans would also be required by the FY 1991 budget proposal to make a downpayment of 4 percent on a loan amount greater than $25,000. Obviously, this would affect virtually all veterans buying homes. One of the most attractive benefits of the home loan program is the absence of the need for a downpayment on most mortgage loans, which allows veterans access to mortgage financing and entry to homeownership.

It is widely acknowledged that one of the biggest obstacles to homeownership in the current economic environment is the inability of renters, or those who must frequently transfer and have little equity buildup, to accumulate funds for a downpayment. To impose this financial burden on veterans, especially in combination with the increased fee, would send to them the message that the DVA no longer wants to guarantee home loans for veterans or to help them become homeowners.

Lenders and veteran borrowers would have little incentive to participate in the VA home loan program if it had mandatory downpayments, given that many of the advantages of VA loans compared to mortgages insured by the FHA are eliminated and the much greater risk to lenders associated with VA mortgages because of the no-bid formula is not eliminated. In the case of a foreclosure of an FHA-insured mortgage, the lender is not faced with a no-bid calculation, the outcome of which currently gives the lender about an 18 percent chance of being left with the property and suffering a significant loss.

THE VETERANS' BENEFITS AMENDMENTS ACT OF 1989, PUBLIC LAW 101-237

GNMA LOAN LIMITS

Public Law 101-237, enacted into law in mid-December 1989, contains a provision that increases the DVA maximum guaranty from $36,000 to $46,000. The current guaranty schedule applies to loans up to $144,000, while loans above that amount are provided a 25 percent guaranty, up to a maximum of $46,000 (which would allow a 25 percent DVA guaranty on a loan of up to $184,000). However, the intent of Congress is being frustrated by inaction on the part of the Government National Mortgage Association (GNMA). VA loans that are used as collateral for GNMA securities are limited to $144,000 and virtually all VA loans are financed through GNMA securities.

Until GNMA takes the necessary steps, veterans are being denied the benefit of pursuing homeownership in high cost housing markets. GNMA is concerned that there will be a greater risk of loss because of the VA no-bid problem. If lenders, suffering from excessive no-bids, default on their GNMA pools, GNMA must make the payments to investors. The underlying assumption for GNMA is that higher balance loans create higher risks of loss and a greater likelihood of lenders defaulting. However, a VA Task Force, formed by MBA in 1989 to study the impact of no-bids, found that most no-bids occur on lower balance loans and that higher balance loans are less risky.

Higher loan amounts are generally concentrated in areas with a solid local economy accompanied by strong employment. Furthermore, a higher loan balance tends to indicate a better quality home in a stable neighborhood. All these factors point to a lower likelihood of foreclosure, the trigger for no-bids.

MBA urges that GNMA take immediate action to raise its loan limits to accommodate the will of Congress for the benefit of veterans waiting to be served by the housing delivery system. Without such a change, VA loans will continue to be limited in the stronger housing markets in the country.

REFINANCE FEE

The refinance fee provision in Public Law 101-237 has proven to be unfair. Veterans seeking an interest rate reduction of a VA loan with a VA refinance must pay the full funding fee of 1.25 percent, without regard to the mortgage's loan-to-value ratio. For the first time, a rate-reduction refinance receives discriminatory pricing vis-a-vis a purchase loan, on which the funding fee is tied to the loan-to-value ratio.

This new policy is neither fair to the veteran nor is it good business for the DVA. A VA rate-reduction refinance does not represent new risk to the DVA In fact, the risk is reduced by lowering the interest rate (and, thus, the monthly payment) and replacing the freely assumable deed with one that requires DVA approval for assumption. Also, given equal loan-to-value ratio loans, the refinance loan is less risky to the DVA than a new loan because the existing lower guaranty remains in effect. In addition, the borrower has a proven payment record at a higher monthly payment, while a new borrower may have an unproven payment record.

Because the veteran may very well have paid a 1 percent funding fee when the loan was originated, the additional 1.25 percent means that the veteran is paying more for the guaranty than is charged for any other VA home loan program. To the extent this fee acts as a disincentive to refinance, the DVA will not receive any additional revenue. The success of rate-reduction refinances should not be jeopardized by an unfair and prohibitive funding fee.

MBA urges Congress to amend the law to remove this inequity.

THE VETERANS HOME LOAN PROGRAM IMPROVEMENTS AND PROPERTY REHABILITATION ACT OF 1987, PUBLIC LAW 100-198

MBA would like to bring to your attention the fact that several provisions of Public Law 100-198, signed into law over 2 years ago on December 21,1987, still have not been implemented. Although the regulations for the mandatory underwriting of VA loan assumptions and for appraisal review by automatic lenders have been proposed, they have not been finalized.

MBA generally supports the intent of the proposed assumption regulations that would enable lenders to make credit decisions on potential assumptors. However, the proposed regulations do not allow lenders to collect fair and adequate compensation for performing the additional tasks associated with processing and underwriting assumptions.

The Department of Housing and Urban Development allows lenders to charge their actual costs up to $500 for processing assumptions of FHA-insured loans, whether or not the assumptor is approved. The Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation allow the lender to charge 1 percent of the balance of the loan being assumed, with a minimum of $400 and a maximum of $900.

The DVA proposal to establish the fee for assumptions at $300 is inconsistent with sound industry standards and is not supported by industry cost analyses of assumption processing. Lenders should not be expected to absorb the losses that will result from the delegation of mandatory underwriting of assumptions.

MBA believes the delay in implementation of the appraisal review provision is also unwarranted. Allowing the lender to review the appraisal and assess the value of the Certificate of Reasonable Value (CRV) issued by the DVA would give lenders additional control over the underwriting of the loan. This is particularly important in economically depressed areas. MBA believes the DVA often issues CRVs with appraised values higher than is appropriate for a given market. Lenders are assuming substantial risks and responsibilities on VA loans because of the current no-bid formula. They should also have the right and responsibility to underwrite those loans adequately. The appraisal is a key element of this process and it is unconscionable that the DVA—even in the face of law—still does not allow lenders to review appraisals.

MBA would appreciate it if the chairman and members of the committee would urge the DVA to issue final rules as soon as possible on the processing of assumptions and appraisals.

MBA would be happy to provide additional material for the record.

STATEMENT OF THE NATIONAL ASSOCIATION OF HOME BUILDERS

Mr. Chairman and members of the committee, we are pleased to present the views of the National Association of Home Builders' more than 157,000 member firms, representing 8 million employees, on the administration's budget proposals affecting housing for America's veterans.

OVERVIEW

Mr. Chairman, before proceeding with our specific comments on the FY 1991 budget proposal, we would like to comment on the VA Home Loan Guaranty Program in general. This program has existed for 46 years dating back to the Servicemen's Readjustment Act of 1944. It was created to assist veterans returning from the war to obtain homeownership. Because of their service to our country, they did not have the opportunity to establish a credit record, or accumulate funds for a downpayment that would have enabled them to purchase a home. Over the years, this VA program has helped almost 13 million veterans to buy a home.

We have worked well in partnership with the Department of Veterans Affairs over the years in providing homeownership opportunities for the men and women who have given of themselves in service to our country. We urge that any changes made in the entitlement nature of the VA Home Loan Guaranty Program be carefully considered so that the benefits of this important program will not be decreased.

VETERANS' HOME LOAN INDEMNITY AND RESTRUCTURING ACT OF 1989

Before commenting on the specific proposals outlined in the administration's FY 1991 budget proposals, it would be worthwhile to review some of the significant changes that were made to the VA Home Loan Guaranty Program by the Veterans' Home Loan Indemnity and Restructuring Act of 1989 ("the Act"), which was enacted last year.

Following is a summary of the relevant portions of the act:

GUARANTY AND INDEMNITY FUND

Under prior law, the Loan Guaranty Revolving Fund financed the operations of the Department of Veterans Affairs loan guaranty program. Loan Guaranty Revolving Fund receipts consisted primarily of fees on guaranteed home loans, income from the sale of properties the department acquired after foreclosure of a guaranteed loan and from the sale of loans the department makes to purchasers of department-acquired properties (vendee loans), interest on vendee loans, transfers from the Direct Loan Fund and appropriations.

The act replaced the Loan Guaranty Revolving Fund with a new revolving fund, called the Guaranty and Indemnity Fund, with respect to loans closed after December 31, 1989. For each loan closed after that date, the Government must contribute 0.25 percent of the loan amount for the fiscal year in which the loan is guaranteed and for the next two fiscal years. (However, the Government contribution for loans made in FY 1990 will be paid in two equal 0.375 percent installments in FY 1991 and FY 1992.)

The act also requires the department to include in the annual budget submitted to Congress certain information about the current and future operations and financial status of both the Loan Guaranty Revolving Fund and the Guaranty and Indemnity Fund.

LOAN FEES

Under prior law, a 1 percent funding fee generally was required to be paid for loans guaranteed by the department, or insured by the department, and for vendee loans. A 0.5 percent fee was required to be paid for assumptions of guaranteed loans. Veterans with compensable service-connected disabilities and surviving spouses of those who died from service-connected disabilities were exempt from these fees.

A downpayment of at least 5 percent was required for loans to purchase manufactured housing.

The act replaces the funding fee with a 1.25 percent indemnification fee, for loans closed after December 31, 1989. This fee is reduced to 0.75 percent if the borrower makes a downpayment of 5 percent or more. Both the indemnification fee and the Government contribution to the Guaranty and Indemnity Fund is reduced to 0.5 percent if the borrower makes a downpayment of 10 percent or more. When the borrower makes a downpayment, the Government must pay an amount equal to the fee that an exempt borrower is excused from paying.

Under the Act, the fees for direct loans, manufactured housing loans and vendee loans remain at 1 percent.

INCREASE IN ENTITLEMENT AMOUNT

Prior law provided a guaranty equal to: (1) 50 percent of the loan amount for loans of up to $45,000; or (2) 40 percent of the loan amount for loans of more than $45,000, but not less than $22,500 or more than $36,000. The maximum guaranty to which a veteran was entitled was $36,000, reduced by the amount of the entitlement previously used by the veteran and not restored. Under the credit standards established by the secondary mortgage market, the maximum amount of the loan that a veteran could obtain with the maximum $36,000 guaranty was $144,000.

The act provided an additional guaranty entitlement for loans that exceed $144,000. This additional guaranty entitlement is equal to 25 percent of the loan amount over $144,000, up to a total guaranty of $46,000. (No fee is charged in addition to the 1.25 percent fee on the total amount of the loan.) Thus, the maximum loan amount can be as high as $184,000.

NO-BID FORMULA

In making a determination whether to acquire property upon foreclosure or to pay the amount of the guaranty, the department must compare the net costs of acquiring the property and reselling it with the cost of simply paying the guaranty amount. In making this comparison, the department must determine the net value of the property.

If the net value of the property is not greater than the amount of the indebtedness minus the guaranty, the department must pay the guaranty and not acquire the property (i.e., a "no bid"). If the net value of the property exceeds the amount of the indebtedness minus the guaranty, the department generally must pay the holder of the loan the amount of the indebtedness and acquire the property. Under prior law, there was no express authorization for including in the no-bid calculation the Government's cost of borrowing funds to acquire the property.

The provision of law setting forth the no-bid formula expired on October 1, 1989. The act extended the no-bid formula through FY 1991. It also prohibited the department from considering any cost of funds in determining the net value of property, for purposes of the no-bid calculation.

FY 1991 BUDGET PROPOSALS

The administration's FY 1991 budget proposes savings of $195 million from several changes to the VA housing program, including:

1. Requiring a downpayment of 4 percent on loans over $25,000;
2. Increasing the indemnification fee to 1.75 percent;
3. Allowing the Department of Veterans Affairs to include the losses that occur on the resale of properties in the net value calculation; and
4. Merging the Loan Guaranty and Direct Loan Revolving Funds.

The administration also proposes to eliminate the Manufactured Home Loan Program, and to allow manufactured home loan guaranty claims to be filed upon receipt of the Department of Veterans Affairs resale price.

DOWNPAYMENT REQUIREMENT

As noted above, the administration has proposed requiring a 4 percent downpayment on all loans over $25,000. As you know, Mr. Chairman, NAHB has always strongly supported the no downpayment feature of the VA Home Loan Program. The fact that no downpayment is required is the major factor that distinguishes the VA program from the FHA program. Historically, the no downpayment feature of the VA home loan program has been viewed as a way to compensate our men and women in uniform who stand ready to defend our country at a moment's notice, and whose cash compensation is less, in some cases considerably less, than their civilian counterparts. Because military personnel generally do not receive sufficient cash compensation to save for the downpayment on a home, the VA Home Loan Guaranty Program has been a tremendous benefit to former military personnel who have served on active duty for their country, and has allowed millions of veterans to realize the American dream of homeownership.

The no downpayment feature of the VA Home Loan Guaranty Program already has been weakened somewhat by enactment of the Veterans' Home Loan Indemnity and Restructuring Act of 1989. As discussed above, that act provided that veterans who make a downpayment of 5 percent or more can have the indemnification fee reduced. While we had concerns with portions of that act, we were generally supportive of its thrust, which was to put the VA Home Loan Program on a sounder footing.

Mr. Chairman, we urge the Congress to reject proposals, such as the administration's proposed downpayment requirement, which would further weaken the key benefit of the VA Home Loan Guaranty Program. Moreover, Congress should allow time for last year's changes to the program to become operative before it considers making other changes. If Congress were to enact the administration's 4 percent downpayment requirement, one might legitimately question the need for continuing the VA Home Loan Guaranty Program at all.

In FY 1989, the average VA loan was used to buy a home that cost about $79,000. This provision would require the average veteran to have an additional $3,160 in cash to purchase a home—a prospect that is particularly daunting for younger first-time homebuyers.

INCREASE IN LOAN FEE

The administration has proposed to replace the funding fee of 1.25 percent with an indemnification fee of 1.75 percent. Just last year, the funding fee was increased from 1 percent to 1.25 percent.

Congress first enacted the VA loan fee of one-half percent in 1982. This came after 38 years in which the program was almost entirely self-supporting and did not require either a fee or Government appropriations. Veterans were able to get a loan because they had earned an entitlement through military service. In 1984, this fee was increased to 1 percent for 3 years. In 1987, the 1 percent fee was extended for another 2 years, and last year it was increased to 1.25 percent.

For 5 out of the last 6 years, the administration has asked for a fee increase. Each time, NAHB has opposed this piecemeal approach to funding the guaranty program with incremental fees, which we believe weakens the entitlement nature of the VA Home Loan Guaranty Program.

Once again, we must oppose a loan fee increase not only because it weakens the entitlement nature of the program, but also because it would increase veterans' housing costs and, in effect, amounts to a new tax, which should be viewed as an increase in revenue at veterans' expense.

Last year, we raised questions about portions of the Veterans' Home Loan Indemnity and Restructuring Act of 1989, including proposals to increase the loan fee. We stated our belief that a 2 percent fee (1¼ percent from the veteran and ¾ percent from the Government) would be insufficient to cover losses in the program on new loans.

Since the current fee structure will not result in a self-sustaining VA Home Loan Guaranty Program, the question of how will future increases in cost be covered must be asked. To keep piling the cost on the veteran would seriously detract from the program's entitlement nature. Accordingly, we would urge that any increase in fee revenue be generated by additional contributions from the Government and not the veteran. At a minimum, we would urge that any fee increase adopted by the Congress be shared equally between the Government and the veteran, rather than being imposed solely upon the veteran.

INCLUSION OF THE DEPARTMENT VETERANS AFFAIRS PROPERTY LOSSES IN THE DETERMINATION OF NET VALUE

The administration has proposed to allow the department to include the losses that occur on the resale of properties in the net value calculation.

The Deficit Reduction Act of 1984 provided a formula that requires the department to pay off the loan guaranty or "no bid" if it is less costly to the Government than acquiring the defaulted property. This occurs when the total indebtedness, defined as unpaid principal plus accrued interest, exceeds the net value by more than the guaranty.

Last year, the Congress extended the "no bid" formula through FY 1991, and prohibited the department from considering any cost of borrowing funds in determining net value. NAHB is pleased both that the Congress extended the "no bid" formula and rejected the notion of allowing the department to calculate an imputed interest charge when it determines whether or not to acquire a foreclosed property, which would add to the cost of funds.

This year, we must raise serious questions about the administration's proposal to change the "no bid" formula. Any change to the "no bid" formula that would result in a higher level of foreclosed properties to be disposed of by lenders, would discourage lenders from participating in the VA Home Loan Guaranty Program. If lenders were reluctant to participate in the program, then it would become much more difficult for veterans to obtain loans and become homeowners.

The administration's proposal would double the current "no bid" rate from 18 percent to 36 percent (roughly one out of three foreclosures).

Because the administration's proposal would add to the cost of foreclosures, and make lending riskier, those lenders who stay in the program will demand higher yields on new loans in the form of increased points to builders/sellers.

The appropriate way to solve the problems posed by potentially bad loans is to work out forbearance programs that keep veterans in their homes if they have any reasonable chance of being able to recover from unforeseen economic reverses.

Accordingly, we urge you to reject the administration's attempt to revise the "no bid" formula.

MERGER OF THE DIRECT LOAN AND LOAN GUARANTY REVOLVING FUND

From the inception of the VA Home Loan Guaranty Program in 1944, until 1961, it was funded through appropriations. In 1961, the Loan Guaranty Revolving Fund (now the Guaranty and Indemnity Fund) was created to provide funding for the program. For over 20 years, the home loan program under the Loan Guaranty Revolving Fund was self-sustaining.

The Direct Loan Revolving Fund supplemented the Loan Guaranty Revolving Fund. It was common practice for transfers to be made from the Direct Loan Revolving Fund to the Loan Guaranty Revolving Fund when there was a deficit in that fund. The Direct Loan Revolving Fund was used to provide funds in areas of the country that were inadequately serviced by mortgage companies. The practice of having the Direct Loan Revolving Fund supplement the Loan Guaranty Revolving Fund was terminated by the Reagan administration in 1981.

While we believe that the Direct Loan Revolving Fund previously served a useful purpose, as an administrative matter, we have no objection to the administration's proposal to merge the Direct Loan and Loan Guaranty Revolving Funds.

ELIMINATION OF THE MANUFACTURED HOME LOAN PROGRAM

Because of the high default rate in the Manufactured Home Loan Program, we do not object to the administration's proposal to eliminate the program.

ALLOW MANUFACTURED HOME LOAN GUARANTY CLAIMS TO BE FILED UPON RECEIPT OF THE DEPARTMENT OF VETERANS AFFAIRS RESALE PRICE

NAHB does not object to this portion of the administration's proposal.

ADEQUACY OF OVERALL LOAN GUARANTY BUDGET, INCLUDING EMPLOYMENT LEVELS

The Department of Veterans Affairs intends to amend its regulations to require that loans with certain characteristics must be reviewed and approved by the department. Furthermore, the department intends to review all applications to verify a veteran's guaranty entitlement, rather than relying upon the veteran's statement.

These proposals no doubt will increase the amount of processing that will have to be done by the department's staff. Moreover, staff shortages in the department's offices throughout the country already are causing significant delays in processing current requests for prior approval and determinations of eligibility.

Accordingly, NAHB urges the Congress, the administration and the Department of Veterans Affairs to provide adequate staff and to direct its field offices to handle, in a timely fashion, the anticipated volume of additional processing that will be required by proposed amended regulations.

GNMA SECURITIZATION OF VA LOANS

Although not specifically part of the subject matter of this hearing, we want to raise a final matter of importance that stems from enactment of the Veterans' Home Loan Indemnity and Restructuring Act of 1989, which provided an additional $10,000 in guaranty entitlement for loans greater than $144,000.

The problem is that loans greater than $144,000 cannot be securitized in the Government National Mortgage Association (GNMA) pools, and, therefore, are unlikely to be extended by lenders until GNMA modifies its current policies and procedures. Apparently, GNMA is reluctant to permit securitization of larger VA loans because of losses it has suffered due to the department's "no bid" policies. However, the department's experience clearly indicates that larger loans perform better than smaller loans.

NAHB has been working with GNMA to raise the maximum limit on the size of mortgages in its guaranteed pools to accommodate VA loans greater than $144,000. We urge the committee to assist us in this task so that the intentions of Congress in enacting the 1989 act can be fully realized.

CONCLUSION

The VA Home Loan Guaranty Program has been in existence for 46 years, and changes should not be made without careful consideration about why the program was created in the first place, whether it will continue to attract qualified members into the uniformed services, and whether it will remain as a benefit to those it was meant to serve. We urge that any changes to the operation of the program in the future be made carefully without jeopardizing the entitlement nature of the VA guaranty.

Congress must continue the responsibility for providing assistance to veterans so that they will continue to have the opportunity to obtain affordable housing.

Thank you for the opportunity to present, for the record, our views on Federal housing policy for veterans.

STATEMENT OF THE NATIONAL ASSOCIATION OF REALTORS

INTRODUCTION

The National Association of Realtors appreciates the opportunity to present its written views on proposals offered by President Bush regarding the Fiscal Year 1991 budget of the Department of Veterans Affairs. As the Nation's largest trade association representing over 800,000 members, we applaud your continuing commitment to promote and maintain home ownership opportunities for our Nation's veterans. The Association continues to believe in the "entitlement" concept underlying the Home Loan Guaranty Program and pledges its support to work with the committee to ensure that the program continues to fulfill its objective of helping veterans buy and remain in their homes.

Our testimony will review and comment on several proposals offered in the Fiscal Year 1991 Bush administration budget for the Department of Veterans Affairs. However, before proceeding with our specific comments on the FY 1991 budget proposals, we would like to address the Home Loan Guaranty Program and the "Veterans Benefits Amendments of 1989" (Public Law 101-137) which was signed into law on December 18, 1989.

"VETERANS BENEFITS AMENDMENTS OF 1989"

The National Association of Realtors testified before this committee in opposition to H.R. 1415, the "Veterans Home Loan Mortgage Indemnity Act of 1989," specifically opposing both the increase in the funding fee and the concept of "blanket" indemnification for veterans who default on the VA guaranteed portion of their loans. The association did, however, support indemnification on a case-by-case basis.

While the association did not support the increase in the funding fee in its testimony to this committee last year, we recognized that the program has required congressional appropriations every year since 1984. This yearly appropriation was the result of many factors including the severe economic downturn in certain parts of the country, increased lender losses associated with the agency's no-bid policy involving foreclosed property, and the decreasing veteran population. These factors, combined with program management problems in appraising, underwriting, and loan servicing, meant that the cost to the DVA of acquiring, managing and reselling properties, exceeded the income realized by the DVA through property sales and loan fees. As a result, since 1984 over $200 million in appropriations has been required annually for the Home Loan Program. These factors underscored the association's view that some sort of major restructuring of the program was necessary in order to ensure its continued economic viability as well as the preservation of the entitlement nature of the program itself.

Accordingly, in September of 1989, leadership of the National Association of Realtors met with staff from both the House and Senate Veterans' Affairs Committees. The committee staff discussed the ever-constant appropriations the program had required, the present budget climate to reduce the Federal deficit, and the necessity of enacting legislation to minimize the costs associated with the Home Loan Program. The National Association of Realtors wishes to again thank the Senate Veterans' Affairs Committee staff who participated in this meeting.

In November, 1989, the association re-examined its policy position with regard to this issue and voted to support H.R. 1415, the "Veterans Home Loan Mortgage Indemnity Act of 1989." While the association remains in opposition to any additional increase in the funding fee, the association believes that an increase in the fee in return for indemnification will enable the program to retain its "entitlement" nature. In addition, the association voted to support two provisions of companion legislation in the Senate, bill S. 1158, which would permit a veteran to acquire additional loan guaranty entitlement by paying a 0.1 fee to 0.25 percent with a 10 percent downpayment. Shortly thereafter, on November 20, 1989, the bill was passed by both Houses of Congress and was signed into law on December 18 (Public Law 101-137). The association is pleased to have been in support of the final legislation, as enacted into law.

FISCAL YEAR 1991 BUDGET PROPOSALS

INCREASE IN FUNDING FEE

The National Association of Realtors opposes the proposed increase in the funding fee from its current amount of 1.25 percent of the loan balance to the proposed 1.75 percent. The new Guaranty and Indemnity Fund (GIF) had only been in existence for less than 1 month when the Bush administration proposed to increase the fee again. The association does not believe that the fee should be raised again, especially without allowing the new program adequate time to prove its effectiveness and cost-saving measures. The association is hopeful that the reforms enacted in this program last year will eventually preclude the annual supplemental appropriation required in recent years and save millions of dollars in Federal funds.

DOWNPAYMENT OF 4 PERCENT

The National Association of Realtors strongly opposes the administration's proposal to require a 4 percent downpayment on the amount of a loan over $25,000. The Veterans Affairs Home Loan Guaranty Program is an entitlement program for those who have served their country. Since its inception in 1944, this program has enabled over 13 million veterans to purchase homes. The very entitlement nature of this program should preclude any attempt by the Federal government to impose a downpayment requirement of any portion of a VA loan. In addition, the proposed downpayment requirement would drastically increase the upfront costs for veterans and represent a tax on veteran homebuyers. The association is deeply concerned by the double-barreled shotgun blast aimed at veterans in this year's budget, i.e., not only a 50 basis point increase in the funding fee but also a substantial downpayment requirement, which will violate the spirit and intent of the Home Loan Guaranty Program enacted by Congress.

CHANGE IN DETERMINATION OF NET VALUE

The National Association of Realtors opposes the administration's proposal to include the Department of Veterans Affairs' losses on resales in the determination of net value. This proposal would allow the DVA to include an average amount of loss that occurs on the resales of properties in the net value calculation when determining whether or not the loan holder can convey the property to the Government.

The association believes the proposal will threaten the very survival of the Home Loan Guaranty Program. Early estimates on this proposal reveal that the rate of no-bids will increase to 35 percent. In other words, if this proposal is enacted into law, lenders would be left with 35 percent of all no-bids. Increases in the proportion of no-bid decisions, will concomitantly result in increased losses to lenders to the point that the latter will no longer be willing to participate fully in the program. In fact, many lenders have already refused to continue in the program; others have imposed downpayment requirements and tightened underwriting. If this proposal is implemented, more lenders will refuse to make VA loans. Consequently, a larger proportion of potential veteran homebuyers will not be able to take advantage of the entitlement program.

INCREASE IN DISABILITY RATING FOR FUNDING FEE EXEMPTION

The "Veterans Benefits Amendments of 1989" allows service-connected veterans with a 10 percent or more disability rating to be exempted from paying the funding fee of 1.25 percent. Further, the new law exempts surviving spouses of veterans whose deaths are related to a service-connected disability from paying the funding fee. The administration's proposal would increase the disability rating to veterans who have a 30 percent or more rating. The National Association of Realtors opposes this increase in the minimum rating for veterans to be exempt from paying the funding fee. As previously stated, the National Association of Realtors believes the Home Loan Guaranty Program is an entitlement program for those who have served their country. Further, the association believes that those who are disabled as a result of serving their country should receive some sort of compensation for service-connected injuries and/or disabilities.

PARTIAL RECOURSE FOR VENDEE LOANS

The association supports the Bush administration's proposal to sell vendee loans with partial recourse to the Government. Both the Congressional Budget Office (CBO) and the Department of Veterans Affairs have compared the results of loan sales without recourse with the results that could be expected from selling with recourse. Cash proceeds from the structured nonrecourse loan asset sales were only 55 to 60 percent of the face value of the loans. Thus, by pursuing a policy of loan sales without recourse, the Department of the Treasury loses around $300 million in cash proceeds in an average fiscal year and will only recover about $260 million of that loss over time. The association acknowledges that veterans are also taxpayers and there is no reason why the Government should not get the best price for its assets.

CONCLUSION

The National Association of Realtors again appreciates the opportunity to submit its views on FY 1991 budget proposals for the Department of Veterans Affairs. The association would like to restate its belief that the restructured program should be given adequate time to prove its effectiveness and self-sufficiency. We applaud your commitment toward—and wish to restate our willingness to assist—a program that will enable our Nation's veterans to purchase homes.

STATEMENT OF HON. BILL NELSON, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

It has recently come to my attention that the administration, in their FY 1991 Department of Veterans Affairs budget request, intends to eliminate the 27 medical district offices and reduce the regional offices from seven to four. I am very concerned that, if implemented, this change will have a deleterious effect on providing health care to our Nation's veterans, and as we are all aware, the problems associated with providing adequate health care are mounting.

I am concerned that individual medical facilities will lose their ability to effectively communicate their concerns to the highest policy-making levels in the Department of Veterans Affairs. If this reorganization is implemented, the special challenges that each facility faces could be lost in the pool of numerous concerns from other facilities located in multiple States.

I believe that it is important for the Department of Veterans Affairs to have the freedom to run their organization with minimal congressional interference, but I hope the department will consider the possible loss of valuable input from these medical facilities if this reorganization goes forward.

Although all of us in Congress are quite aware of the budget constraints the country faces, the providing of care to our veteran population is one place we should not skimp. These individuals deserve the best of care for the sacrifices they have made for this country. They require a medical system that is responsive to regional needs.

STATEMENT OF THE NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

The Non Commissioned Officers Association of the USA (NCOA) appreciates this opportunity to comment on budget proposals for the Department of Veterans Affairs for Fiscal Year 1991. For the first time NCOA has endorsed the efforts of our colleagues in veterans services by endorsing the Independent Budget of Veterans Organizations. However we feel compelled to commend the administration's budget submission as the best to have been offered in the past 10 years.

President Bush has proposed spending on behalf of veterans in 1991 totaling $30.9 billion. Included therein are proposals to increase medical care funding, improve pay for nurses, doctors and dentists, and increases in funding for construction and renovation of VA facilities. By comparison with the budget submissions of his predecessor the Bush proposal is remarkably generous and obviously thoughtfully prepared. Yet the proposal is built on a false foundation. It presumes previous submissions were adequate and it does not recognize that the shortcomings of previous submissions have left the department grossly understaffed, underfunded, and working in facilities which are frequently inadequate and poorly equipped.

THE PRICE OF PEACE

Veterans deserve better than they have been provided in the past decade. And, that means better than the treatment they would receive under the President's budget proposal however well intentioned it might be.

To the point—their is a price for peace which the United States must continue to pay. Part of that price is vigilance manifested in maintaining an Armed Forces capable of dealing with any threat. Equally important is paying the price of supporting those who have made peace possible. If peace is breaking out all over the world who deserves to benefit from the Peace Dividend more than the veteran who made it possible.

BENEFIT PROGRAMS

NCOA at this point restates its support for the Independent Budget of Veterans Organizations but also feels compelled to comment on several aspects of the administration budget.

COMPENSATION

The administration has proposed several changes in benefit programs this year. Foremost the budget forecasts a 3.9 percent cost-of-living adjustment in compensation and survivor benefits. Additionally the administration proposes once again to index compensation and survivor benefit cost-of-living adjustments to increases in the Consumer Price Index. NCOA is not prepared at this point to endorse a fixed increase, amount in veterans benefits. Instead the association will continue to rely on congressional efforts to match the measured increase in the Consumer Price Index nearer the date of adjustment. Moreover, while this requires congressional action it is the very reason we oppose indexing of benefit increases. The necessity of congressional action to provide adjustments in compensation and survivor benefits each year serves as the impetus for review of other veterans programs in need of attention. In a sense the compensation increase is the engine that drives the train of congressional action on all veterans benefits and must be maintained.

Also proposed in the administration budget is a limitation on compensation payments to incompetent veterans. If enacted it would restrict the estate value of veterans to $25,000 discontinuing compensation payments at that point and reinstating payments when the estate value is reduced to $10,000. The proposal will prevent distant relatives from receiving a windfall inheritance upon the death of the veteran according to the administration and save $170.1 million in annual compensation outlays. NCOA supports this initiative but urges the committee to give the Secretary authority to provide exemptions as deemed necessary in the best interest of the veteran.

PENSION

The pension program is the subject of two legislative proposals in the administration budget. The first would extend the allowable hospitalization period preceding benefits reduction to 1 year. Currently pension payments are reduced to $90 after 90 days of hospitalization. As a result many veterans are unable to leave hospitalization after 90 days even when medically capable because they have been unable to make house, apartment, car, and utility payments or other commitments because of the reduction in their pension benefits. The second pension proposal would allow a comparison of Department of Veterans Affairs and Internal Revenue Service records to determine overpayments. NCOA supports both of these proposals.

JOB TRAINING

With regard to veterans job training NCOA commends the attention of the committee to a funding inadequacy resulting from the passage of Public Law 100–323. As stated in the Independent Budget, Congress failed to fund training for the first year of a 2 year extension of the Veterans Job Training Act. Accordingly we urge the committee to seek supplemental appropriations of $60 million (the congressionally authorized amount) to fund the program during the current fiscal year.

EDUCATION

Neither the Independent Budget or the administration proposal contains any new initiatives regarding education programs for veterans, a condition NCOA deems unfortunate. On December 31, last, tens of thousands of Vietnam-era veterans lost their entitlement to education benefits based on their wartime service. Their only sin was to have remained in the Armed Forces too long. By extending their service to their country many unknowingly sacrificed their chance for a college education because of an arbitrary benefits cutoff date established by Congress. NCOA believes Congress should redress this situation and urges the committee to seek funding necessary to continue the Vietnam-era education program until all otherwise eligible veterans have had a full 10 years in which to use their benefits.

Additionally, NCOA believes it is incumbent on Congress to initiate the refund of Montgomery G.I. Bill pay forfeitures to those individuals who participated in Operation Just Cause. NCOA continues to believe it is inappropriate to charge any servicemember for participation in an education program. Fees go against the nature of the issue. They discriminate against the economically disadvantaged and reduce participation in a program which by historical comparison will pay for itself many times over in higher tax revenues on increased earnings made possible by higher education.

Moreover, Congress, in justifying the collection of fees for participation in the Montgomery G. I. Bill, made clear its intention to waive fees for those who participated in combat action. As a matter of integrity and credibility NCOA urges Congress to take immediate action to make all Just Cause participants eligible for free Montgomery G.I. Bill benefits.

LOAN GUARANTY

NCOA appreciates the efforts made by Congress last year to resolve long-term deficits in the Veterans Home Loan Guaranty Program. Furthermore, we believe those new initiatives should be given a chance to work. Accordingly, we cannot endorse any of the legislative requests outlined in the President's budget proposal. However, we should also add that those legislative requests should fail not just because it is too soon to modify the new program, but because they are bad ideas.

The President has asked Congress to increase program participation fees by one-half of 1 percent raising the fee to 1.75 percent and asked that it be applicable to all veterans with disabilities of 20 percent or less. Additionally the budget suggests that all loans made to veterans be supported by a minimum down payment of 4 percent. These proposals cut to the heart of the primary benefit of the guaranty program—the no down payment requirement—which is most beneficial to the first time homebuyer.

Additionally, the budget proposes termination of the Manufactured Housing Loan Guaranty Program. While NCOA concedes the need to do something to address the high foreclosure rate in this program, we believe program termination should be a last resort. Buyer education initiatives, better underwriting criteria, more zealous policing of the industry and better post default counseling could all work to decrease foreclosures. Additionally, simple negotiation between the Department of Veterans Affairs and the Department of Defense regarding policies on the placement and transfer of manufactured homes could also cure many of the problems leading to default. And, negotiations between the two departments might also provide a market for manufactured homes currently in the inventory if DoD might be persuaded to acquire those units for use as much needed junior enlisted housing.

Finally, the budget proposes to consolidate the Loan Guaranty and Direct Loan Revolving Funds and to add DVA losses to the net value calculations used to determine whether the department will acquire a home in default. Over the past 10 years the LGRF has borrowed $1.7 billion from the Direct Loan Fund decimating its value. NCOA sees no reason why the remaining $26 million should not be consolidated into the LGRF. Our only regret is that Congress has not reopened the direct loan program as a method of recapturing the losses these funds have suffered. NCOA strongly objects to additional modification of the net value calculation however. Under current law and regulation the Department of Veterans Affairs already claims 12 percent of the value of any veteran's home which falls into foreclosure as its handling fee. Any increase would only be passed to veterans as additional indebtedness.

INSURANCE

NCOA urges the committee to be open-minded to proposed increases in Servicemen's and Veterans' Group Life Insurance SGLI/VGLI programs this year. The Independent Budget supports initiatives to improve Veterans Mortgage Life Insurance, an overdue action strongly supported by NCOA. In addition, DoD in a January 5th letter to the Speaker of the House and President of the Senate has asked Congress to modify section 777 of title 38 to allow military retirees who are subject to recall to be allowed enrollment in VGLI on a renewable term basis until they reach age 60. NCOA has supported this idea in testimony for 3 years and is pleased to see the Defense request for action.

MEDICAL CARE

The Veterans Health Services and Research Administration (VHS&RA) is, according to the administration budget, the beneficiary of a $1 billion increase over FY 1990 funding levels. Additionally the administration proposes a Full Time Equivalent Employee (FTEE) increase of 2,599 according to volume 2 of the budget request. As laudable as the intent is in such an increase, the figure is misleading in its suggestion of growth in medical care expenditures.

DEBT CARRY-OVER

The President has requested $12.3 billion for medical care spending in FY 1991 but in real dollars $13.4 billion would be required to restore medical care spending to an FY 1988 current services level. Fiscal years 1989 and 1990 both represent severe shortfalls in medical care spending. For example, Congress generously added nearly $1 billion to the administration request for medical care spending in FY 1990, the current fiscal year. Sequestration during the first quarter robbed the VA of $158 million. Another $94 million was lost to an error in salary calculations. Subsequently, $65 million was diverted to the war on drugs. Nearly $300 million in capital outlays has a restricted availability date of August 1 encumbering care availability in the current fiscal year. Absent supplemental appropriations VHS&RA must survive on a combination of internal borrowing for necessary outlays, and purchase delays in necessary equipment. The net result is that all these items become debt carried forward into FY 1991.

NEW OBLIGATIONS

Altogether the VHS&RA can be expected to carry forward a debt of between $250 million and $350 million into FY 1991. The value of the billion dollar increase in the President's budget is reduced accordingly. The January 1 Federal employee pay raise and its associated additional costs will claim another $450 million. Finally, the President has proposed a $70 million initiative to improve pay for health care professionals. NCOA does not suggest that any of this represents wasteful spending. In fact, we support all of these expenditures and initiatives, but none represents growth in VHS&RA patient services.

REAL GROWTH

Real growth in medical care spending may not be possible given the current economic environment. The Independent Budget of Veterans Organizations, as ambitious as its proposals sound, does not propose real growth. Yes, it proposes $1.3 billion in increased spending which approximates an FY 1988 current services level. It does seek to direct the VHS&RA toward targeted and necessary improvements in the health care system to meet the changing needs of veterans.

SIXTEEN PERCENT SOLUTION

Currently 6.7 million veterans are 65 or older. By 1999 that number will peak at an estimated 9 million. Yet VHS&RA is ill prepared to handle either the long-term or acute care needs of this population. During the 1980's the Veterans' Administration positioned itself well to deal with the needs of the aging veteran by excluding through economic discrimination from medical care a large portion of its beneficiary population. But its lack of continued planning has left the department unable to cope with these individuals. Last June the department announced it was preparing to deal with only 16 percent of the anticipated geriatric patient load expected by the end of the century. Moreover, it expects to contract 70 percent of that care. As revealed in a December seminar, the department seems more concerned about what will happen in the post boom years after 2010 when the veterans population begins to decline. Thus, to the administration, a solution of providing care for only 16 percent of the beneficiary population makes sense. Obviously, a great many veterans will suffer in their senior years because of this thinking.

NCOA urges Congress to review and enact the Independent Budget of Veterans Organizations. For the relatively few dollars difference it proposes several new and innovative ways to begin caring for our veteran seniors. In the out years we believe its approach to providing hospital based home care, layered long-term care facilities and new geriatric evaluation units will save outlays.

RESEARCH

The President's budget proposes to cut VHS&RA research funding by nearly $17.5 million dollars and 421 FTEE in FY 1991. Such cuts could be catastrophic. In recent years DVA research programs have already been cut nearly 2 percent and a continuing decline will be reflected in increased health care costs incurred by people suffering from maladies for which a cure, with continued research funding, is within reach. Since 1985 other Federal health research outlays have increased by nearly 13 percent. It makes little sense to cut only DVA research programs which have been among the most successful in the nation.

THIRD PARTY REIMBURSEMENT

Again the administration has proposed the collection of insurance benefits for care provided to certain privately insured veterans. NCOA continues to oppose this concept of veterans medical care financing. The association believes the $25 million and 800 FTEE recommended for this program would be better utilized in other roles. Additionally, we view this program only as an Office of Management and Budget gimmick which we anticipate they would use in the future to reduce appropriations by the value of both collected and uncollected funds.

FEE COLLECTIONS

The administration has also proposed a program of fees to be charged to veterans seeking certain non-service-connected care. The ill defined proposal would charge veterans $5–$10 per outpatient visit, $3–$5 for prescriptions and $9 per diem for each day of hospitalization. In recent years Congress has demonstrated great wisdom in rejecting similar proposals to charge such fees of beneficiaries in the military medical care system. Having concluded that such fees might interfere with the provision of necessary health care and that tremendously high administrative costs could rob the program of any long-term value, Congress has sagely decided not to implement such fees in the military care system. Hopefully, Congress will offer this same protection to veterans.

Hospital Commission

In the absence of congressional support for a legislated Medical Realignment Commission, the Secretary has announced his intention to establish a blue ribbon panel to examine the VA's medical program. It will focus on supporting efforts in AIDS, spinal cord injuries, alcoholism, geriatrics and post-traumatic stress disorder. Hopefully, the Secretary will also ask the panel to evaluate mission realignment and explore the need for new or alternative facilities and system expansion. NCOA does not support a legislated commission such as the one proposed earlier along the lines of the Defense Base Closing Commission. We believe the agenda of such a panel would pare away at the system instead of entering into a realistic exploration of whether and how the system should be expanded and improved. Without the pressure of all or nothing approval we believe a blue ribbon panel may present a report worth consideration. We commend the Secretary on this initiative.

CONSTRUCTION

The President's construction budget proposal contains the same lack of foresight in planning as discussed in medical care. Notwithstanding administration efforts to provide a reasonable construction budget, it is severely flawed in priorities and funding level. At the rate of construction proposed by the administration it will take 82 years to modernize the health care complex. Furthermore the system will never reach the level of nursing beds needed to serve the aging WW II veteran population. Finally, the construction budget does nothing to provide for necessary expansion of the National Cemetery System, a purposeful omission which only further exacerbates the problem of accessibility to burial in a national cemetery among veterans.

Once again NCOA asks that special consideration be given to enactment of the construction provisions of the Independent Budget. The proposals contained therein more adequately address the needs of veterans than the need to reallocate space in the department's central office.

GENERAL OPERATING EXPENSES

The continuing erosion of funding in general operating expenses has led to a significant number of problems. Most notable is the backlog of compensation and vocational rehabilitation claims. Currently more than 650,000 compensation and pension claims are awaiting adjudication requiring a wait of more than 6 months. Vocational rehabilitation applicants must wait an average of more than 3 months for an initial interview and another 3 months for claims processing. Veterans in default on home loans lack counseling on ways to resolve their indebtedness shy of foreclosure. Recently separated veterans seeking veteran's benefit counseling find that in 24 of 70 major population centers their are no counselors available for one on one meetings. In fact, 40 percent of all benefit counselors are still in training and are frequently too ill trained and supervised to conduct counselor sessions. The problems that exist now will be compounded by the reductions in force planned for the armed services in the years ahead.

Automation efforts have and will continue to help the department cope with its increasing caseload, but these efforts are not enough. The only real solution to the problem of case resolution and counseling is to provide adequate staffing. The administration budget proposes a net GOE staffing reduction of 233 FTEE. Conversely, the Independent Budget proposes a staffing increase of 734. NCOA asks Congress to adopt the Independent Budget request.

SUPPLEMENTAL APPROPRIATIONS

Noted throughout our review of the budget proposals are observations about current shortfalls in veterans spending. These shortfalls now total about $300 million. That figure could easily rise in an emergency or national disaster. Therefore we urge Congress to go forward with a supplemental appropriations request to fund the improvements NCOA has asked for in education programs, job training and to fund the known sequestration and salary losses in medical care.

CONCLUSION

Once again we commend the efforts of the President for sending to the Hill a proposal for veterans spending which conscientiously tries to provide for veterans needs. Nevertheless, we believe the Independent Budget of Veterans Organizations, for a difference of only $1.3 billion provides a much more realistic picture of the needs of veterans.

STATEMENT OF THE NURSES ORGANIZATION OF VETERANS AFFAIRS

Mr. Chairman and members of the committee, I am Claudette Morrissey, president of the Nurses Organization of Veterans Affairs (NOVA), and a registered nurse employed full-time as a Staff Nurse at the Veterans Affairs Medical Center, Brooklyn, NY. On behalf of NOVA, it is my goal to address the needs of the veteran patients cared for by over 32,000 RNs in the 172 VA hospitals and 200 outpatient clinics. It is NOVA's goal to help assure that veterans needing health care, promptly receive quality care. VA nurses are in the forefront in programs caring for veterans in the full continuum of acute and long-term hospital care, as well as nursing home care, ambulatory care and home care.

NOVA was gratified to see that the administration has indicated a commitment to veteran health care by presenting a budget that includes an increase of $901 million in the health care budget. The administration's budget proposal, while a good start, is not a solution because it is based on an increase over last year's inadequate budget which has resulted in VA currently being $700 million below the level of funding needed just to maintain FY 1988 services. Past inadequate VA appropriations have jeopardized the quality and quantity of VA health care. Funding for VA health care must remain a priority, if we are to fulfill our obligations to our Nation's veterans. Less money means restricted care which means patients do not receive the care they need. When needed medical or psychiatric treatment is delayed or compromised, patients become more acutely ill and require more costly emergency care. Hospital stays are often prolonged and rehabilitation is less effective due to additional problems or complications arising from delays or restrictions.

As NOVA has reported, the inadequate medical care budgets of the past have had an adverse impact on the ability of the VA to recruit and retain adequate numbers of VA nurses. Competition for registered nurses exists, and VA is unable to compete for this scarce human resource. At the end of FY 1988, the national vacancy rate for VA nurses had increased from 2.8 percent to 5 percent, and the turnover rate had increased from 16.1 percent to 26.5 percent. These percentages translate into 1,750 vacancies and 9,000 registered nurses leaving their positions. The shortage of registered nurses is serious at a time of increased patient acuity. A greater turnover of patient admissions and discharges, an increase in elderly patients with multiple system diseases, the homeless with multiple social and health needs, patients with AIDS, patients needing treatment for PTSD and substance abuse, all require more nurses in multiple settings.

The inclusion of $31.36 million in the administration's budget for nurse pay reform proposal is a tribute to the efforts of this committee, and a reflection of the Secretary of Veterans Affairs commitment to veteran health care. It has been evident that the present nurses pay schedule which is linked to the Government-wide general schedule is inadequate when over 140 of the 172 hospitals have special salary rates for nurses. The use of special salary rates has increased the magnitude of salary compression. Beginning VA nursing salaries have not kept up with the private sector. Career VA nursing salaries suffer pay compression and progress very little when compared to other professions in which career earnings double or triple. Even in this time of budget deficits, it must be recognized that financial and work place incentives are required. The present reliance on special rates or periodic adjustments for specific categories of RNs only allows for temporary catchup which is more costly in terms of high vacancy and turnover rates, job satisfaction, and continuity of care for patients. The report mandated by Public Law 100–322 and completed by the Klemm Analysis Group confirmed that special rate changes take too long, and by the time they are approved, the wage is obsolete. A more permanent, positive change is imperative. The time for a revision of the basic pay system for title 38 RNs is now. We must not allow this year to end without a pay reform package for registered nurses.

Nurse pay reform must include:

—Salary rates that are competitive with the community, with a sufficient number of steps and levels, to avoid the pay compression that now occurs between newly hired nurses and career nurses, as well as between nurses at the lowest and highest grade levels;

—Removal of the cap on special salary rates that limits it to a maximum of 19 steps;

—Removal of the pay cap from overtime pay for registered nurses;

—Increasing the pay differential for evening and night shifts;

—Premium pay for nurses with additional responsibilities such as head nurses, and clinical coordinators.

Nursing is not the only area where there have been staff cuts and shortages. There are shortages in other departments and nurses are required to fill in the gaps as respiratory therapists, blood drawers, ward secretaries and housekeepers. The Army, Navy, and Air Force were provided $60 million in FY 1990 to hire additional support personnel to help with the problem of military nurses performing nonclinical tasks. NOVA urges that a similar effort is indicated for the VA health care system.

The continuous restraints of the budget have also resulted in the low nursing staff to patient ratio and the requirement of shift rotation by a large majority of VA nursing staff. Studies of VA nurses over the past 20 years have all revealed a problem with shift rotation. According to the Klemm report, the requirement of shift rotation by VA, while other hospitals do not, may be the one significant item that distinguishes the VA work environment from its competitors. VA nurses do not need another study of shift rotation. Funding is needed for an additional 4,800 FTEE to improve the nurse-patient ratios and to help assure permanent shifts for all VA RNs.

NOVA is pleased to see the inclusion of $1.7 million for health professional scholarships in the budget and strongly opposes VA's request for reprogramming of funds that support nurse scholarships. These scholarships have resulted in 745 nurses currently working for VA under scholarship obligation. The loss or the reduction of the scholarship program would be a grievous blow to VA's ability to recruit qualified registered nurses and keep them long enough to commit to a career as a VA nurse.

Without supplemental funding for FY 1990 and sufficient funds for FY 1991, VA medical centers will continue to have difficulty attracting and retaining nurses. The care of veterans is at risk. Nurses will continue to leave VA for other health care settings, and even restored beds will remain empty, without nurses.

VA must no longer try to meet the budget targets by making unreasonable demands of nurses and breaking its covenant with sick and needy veterans. As the pressure has built to treat sicker patients in a more rapid time frame, VA nurses have done their part. NOVA is speaking today for the nurses who continue to stay and care for veteran patients in spite of all the difficulties caused by budget constraints. We are loyal and dedicated employees who pull together in difficult times, who like taking pride in what we do and dislike seeing the VA attacked and criticized from without. However, we are deeply concerned about both the image and reality of VA nursing, particularly as reflected in significantly heavier workloads and in nonregular shift work, keeping it unattractive and noncompetitive. We have glimpses from time to time of how great the VA health care system can be and take pride in the system's accomplishments. We have a worthy mission and need the resources to fulfill that mission.

In conclusion, VA health care policy is a matter of budget policy, and NOVA urges you to carefully examine the administration's budget proposal and support the effort it makes to begin to improve veteran health care, but also urge you to see the areas in which the budget is inadequate. We also commend and endorse the Fiscal Year 1991 Independent Budget for Veterans Affairs, and urge the committee to consider the intelligent and perceptive approach to the funding of VA medical care reflected in this document.

Thank you for the opportunity to present this statement.

STATEMENT OF HON. LAWRENCE J. SMITH, U.S. CONGRESSMAN FROM THE STATE OF FLORIDA

On behalf of the 57 veterans organizations that comprise the Broward County Veterans Council, I would like to express my concern about the department's decision to abolish the system of medical districts. These organizations believe that placing administrative decisions in the hands of a few regional offices rather than in several local district offices will hamper the ability of individual hospitals to communicate their needs and receive funds.

An advisor to the Veterans Council explained: "The recent decision by the Secretary of the Department to do away with the 12th medical district is going to have a possible drastic effect on the distribution of funds. This decision takes away a great amount of the ability to get messages of need to the Home Offices. This decision is looked upon as another grave threat to medical care."

Our Nation's veterans deserve a health care system that is responsive to their needs. As you can see, however, many of the veterans in my district believe that the proposed reorganization will be counterproductive to this goal. I urge you to keep their concerns in mind as the department begins to consider implementing any new organizational plan.

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

March 6, 1990

Honorable Alan Cranston, Chairman
Senate Veterans Affairs Committee
414 Russell Senate Office Building
Washington, DC 20510-6375

Dear Senator Cranston:

During February 23, 1990, testimony before the Senate Committee on Veterans Affairs regarding the Department of Veterans Affairs' (VA) Fiscal Year 1991 budget you requested we provide you a detailed written analysis of the compensation and pension claims backlog reported in the Fiscal Year 1991 Independent Budget.

Since the Disabled American Veterans is responsible for preparation of the Veterans Benefits Administration (VBA) portion of the Independent Budget, I am enclosing a copy of our white paper describing the methodology employed by the Independent Budget to arrive at our figures, and a comparison of our compensation and pension backlog figures with those recently reported by the VA for Fiscal Years 1988 and 1989.

It is our understanding this white paper will be incorporated into the official record of the Committee's February 23, 1990, hearing on the Fiscal Year 1991 budget.

On behalf of our Independent Budget colleagues at AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars, we very much appreciate your interest in this most important subject matter and, of course, your long-standing exemplary commitment to our nation's veterans.

Sincerely,

JESSE BROWN
Executive Director
Washington Office

JB:lmc
Enclosure
cc: AMVETS
Paralyzed Veterans of America
Veterans of Foreign Wars

THE COMPENSATION AND PENSION (C&P) PENDING BACKLOG

In an effort to explain the markedly different pending figures provided by the VA and Veterans Service Organizations, we have (1) updated our data to reflect pendings at the end of FY 1988 and FY 1989 (rather than at the end of 8/88 and 8/89) and (2) used our methodology to calculate the change in the pending between 10/1/87 and 9/30/88. We did this to determine if our methodology would yield such disparate results (compared to the VA data) when applied to FY 1988 as it did for FY 1989.

This exercise reveals basic flaws in the VA's accounting/reporting system for which there reportedly is no effective internal correcting mechanism. In our view, the system defies rational explanation.

To understand what follows, it is important to realize that the baseline was provided by the VA. The VSOs assumed that the actual pendings provided to us by the VA in connection with prior Independent Budgets (IBs) were accurate, i.e., the total C&P pending as of 10/1/87 was 167,687 and the pending as of 8/31/88 was 362,935. In view of subsequent events, the credibility of any pending data provided by the VA is subject to question but, after lengthy analysis, we believe the 10/1/87 and 8/31/88 pendings are reasonably accurate. This is because those figures are consistent with all the facts. The same cannot be said about the pending C&P figure of 343,199 at the close of FY 1989 provided by the VA. Here's why.

In the FY 1990 IB, the VSOs repeated the pending figure provided by the VA - 362,935. Subsequent to the HVAC's hearings on the FY 1990 VA budget, the VA challenged the 8/31/88 pending figure cited in the IB to Committee staff, stating that VA reports showed the pending at approximately 170,000. In any event, a year later, the VA reported to the Committee staff that the pending as of 9/30/88 was 368,927 (a figure reasonably consistent with the IB). Having relied on data supplied by the VA and then being subsequently challenged by the VA advising Committee staff that the C&P pending was really far less than stated by the VSOs, we determined that it was in our best interest to calculate the C&P pending in the FY 1991 IB independently using the most objective data available. This turned out to be a judicious decision.

To test the accuracy of the 8/31/88 pending of 362,935 as well as the substantially revised 9/30/88 pending figure recently provided by the VA (368,927), we applied our methodology to VA reporting data for the period 10/1/87 to 9/30/88 (FY 1988). The methodology, using the 3DKl reports for the 12-month period ending 9/30/88, reveals the following:

	C&P Orig.	Adj./ Suppl.	Ancillary	Total
Pending 10/1/87	43,571	107,387	16,729	167,687
Receipts 10/1/87-9/30/88	767,953	1,930,960	391,787	3,090,700
	811,524	2,038,347	408,516	3,258,387
Dispositions 10/1/87-9/30/88	707,166	1,740,211	405,543	-2,852,920
Pending-10/1/88	104,358	298,136	2,973	405,467

Because of the VA's system of reporting on a 12-month cumulative basis, updating the VSOs' (and VA's) pending figure from 8/31/88 to 9/30/88 is not as easy as one would expect. We compared the receipts and dispositions shown on 9/30/88 and 8/31/88 3DK1 reports. It is worth observing that this exercise does not really capture what happened in the most recent month (9/88), i.e. the number of receipts and dispositions by claims categories. It updates the cumulative 12-month total. Thus, the differences in pluses and minuses between the 8/31/88 and 9/30/88 reports are actually the differences between 9/88 and 9/87. All that has occurred is that 9/88 replaced 9/87 in the cumulative 12-month total.

We calculated the increase in the pending between 8/31/88 and 9/30/88 as follows:

Month of 9/88 (add on to 8/88 total)

	Orig.		Adj.	Ancil.	
Receipts	767,953	(9/88)	1,930,960	391,787	
	767,100	(8/88)	1,938,441	389,338	
	+ 853		- 7,481	+ 2,449	- 4,179
Dispositions	707,166	(9/88)	1,740,211	405,543	
	705,886	(8/88)	1,766,160	398,383	
	+ 1,280		- 25,949	+ 7,160	- 17,509

+13,330 total pending over 8/31/88
362,935 - IB
376,265 - 9/30/88

The difference between revised VA pending for 9/30/88 of 368,927 and the pending calculated by using the IB methodology for FY 1988 -- 405,467 is 36,540. This is 1.2% of the 3,090,700 C&P claims receipts reported for FY 1988 or 1.3% of the 2,852,920 dispositions reported for FY 1988. If the 8/31/88 pending of 362,935 is considered accurate and the IB methodology is used to update it by a month, the pending as of 9/30/88 would have been 376,265, a difference of 7,338 from what the VA reports as the 9/30/88 pending. The difference is .002% of total C&P FY 1988 receipts and .003% of FY 1988 dispositions.

Not perfect, sloppy in fact, but a model of precision compared to what occurred with respect to similar data for FY 1989. The 3DK1 report for the 12-month period ending 9/30/89 shows receipts exceeding dispositions as follows:

	Orig. Claims	Adj./Suppl.	Ancillary	Total
Receipts	810,958	1,954,237	490,806	
Dispositions	731,946	1,755,572	458,952	
	79,012	198,665	31,854	309,531

Using the simple, common-sense, and universally-accepted method of calculating the pending as of 9/30/89, i.e., adding receipts to the beginning pending and then subtracting FY 1989 dispositions from that total, results in a 9/30/89 pending of 678,448 (if the VA 9/30/88 pending of 368,927 is used as the opening pending). If the updated VSO pending for 9/30/88 of 376,625 is used, the 9/30/89 C&P pending would be 686,146. Incredibly, the VA states that the 9/30/89 C&P pending declined to 343,199!

Using the VA's figures -- a 9/30/88 pending of 368,927 and their report of receipts and dispositions, the VA's reported 9/30/89 pending is off by 335,249 (678,448 - 343,199 = 335,249). Total C&P receipts by the VA for the 12-month period ending 9/30/89 were 3,256,001 and total dispositions were 2,946,470. The 335,249 discrepancy in the VA reporting system represents 10.3% of total FY 1989 C&P claims receipts reported and 11.4% of total dispositions. This should be compared with the comparable data from the prior year, using exactly the same methodology -- a claims discrepancy of 36,540 for FY '88 compared to 335,249 for FY '89 with the FY '88 discrepancy representing 1.2% of receipts and 1.3% of dispositions compared to the FY '89 percentage of 10.3% and 11.4%, respectively.

Thus, in a single year, the discrepancy in the number of pending claims (as disclosed by internal contradictory VA reports) multiplied ten-fold, resulting in the apparent understating of the claims backlog by almost 100% (343,199 vs. 678,448).

There are two obvious possible explanations, neither of which reflect well on the VA.

1. The VA is attempting to hide the real claims backlog in order to mask the budget resource needs of C&P service.

2. The VA has a reporting/accounting system that produces contradictory data. In a single year, the system has provided data that overstates the pending by more than 10% of total receipts, with the result that the pending is actually half of what the reported data shows. Moreover, apparently, there is no effective internal correcting mechanism to balance the books with respect to receipts and dispositions.

Let's examine the possibilities. If the second possibility is entirely accurate, then none of the claims-related data reported by the VA has any credibility. Any system that could overstate receipts by 335,000 in a year is worthless. Moreover, a management that would permit the continuance of such a system is, to put it charitably, inept.

Although the VA's computer systems are antiquated, no system exists which would produce the magnitude of the errors which the VA says caused the discrepant pending figures.

The VA explains that the 3DK1 receipts may lead to duplicate counting of cases. The pending issue is often established without the claims folder. When the mail is associated with the claims folder, the pending issue may be cancelled and a new issue established, thereby, showing two claims received.

The problem with this explanation is that "cancelled" means to delete or remove. Surely, the system has the capability of deleting or "cancelling" an incorrectly identified claim or issue and, if necessary, replace it with a correctly-identified claims receipt. If, indeed, a receipt is cancelled or reflected as a disposition, there is no discrepancy. We presume that the computer system is programmed to do exactly that.

Even in the most unlikely of circumstances, i.e., the system was unable to cancel (delete) incorrectly-identified receipts, how could a competent management fail to take measures to ensure some element of reliability in its reporting system? If the 9/30/89 pending reported by the VA is accurate, it is because more than 335,000 basic errors were committed with no attempt made to correct them. This, we think, is inconceivable.

Turning now to the first explanation, we are convinced that the pending is much higher than reported by the VA. We believe the pending is a close approximation of the VSOs' estimate. We believe this is verified by the testing of our methodology for FY 1988. We do not, however, believe that the VA has knowingly understated the pending to justify not requesting needed FTEEs. The explanation is that top VA management has a limited understanding of what the real pending is because of their seriously flawed reporting/accounting system and, therefore, is unaware of what their true resource needs are.

Other facts support the VSOs' position. By all accounts, timeliness of C&P claims adjudication continues to worsen. We do not think this is possible if the backlog had actually stabilized or decreased. Timeliness would have to improve in a declining backlog scenario.

The FY 1991 CP&E budget justification is replete with statements and statistics showing continued deterioration in quality and timeliness. They relate this directly to insufficient FTEE levels. With respect to backlogs, the Administration's FY 1991 budget states:

> "The declining FTEE in recent years has resulted in a backlog of cases being processed. The mounting backlogs have had the effect of increasing the pending workload at the end of each year for several years."

If the backlog had stabilized and begun to decline during FY 1989 as the VA now contends, one would think that CP&E would be aware of this and that the "good news" surely would have been prominently displayed in the Administration's budget submission. Moreover, the whole tenor and tone of the CP&E budget justification would appropriately be expected to be much more upbeat.

In closing, we observe that this latest episode in the pending claim controversy highlights major problems with the VA's C&P claims reporting/accounting system and management's use of it. We believe an independent audit of this situation is long overdue. The current fiasco cannot be repeated.

Congress, the VSOs, and particularly the VA must know exactly how many C&P claims are pending. Otherwise, there is little hope that the workload can be managed effectively or that the resources needed to do so can be determined accurately. Because of our interest and involvement in this issue, the VSOs would like to have input in the development of the protocol for the much-needed audit of the VA's C&P claims reporting/accounting system.

THE RESPONSES OF CHIEF JUDGE FRANK Q. NEBEKER, UNITED STATES COURT OF VETERANS APPEALS, TO THE PRE-HEARING QUESTIONS SUBMITTED BY CHAIRMAN ALAN CRANSTON, SENATE COMMITTEE ON VETERANS AFFAIRS

The Court respectfully provides the following responses to the pre-hearing questions submitted by Chairman Alan Cranston:

Question 1. On page 2 of the Court's budget submission for FY 1991, it is stated, "The Court anticipates legislation that will bring the salaries paid to the Court's six associate judges to the traditional level with that salary paid to the chief judge of the Court. However, the President's budget did not, and indeed could not, anticipate the funding necessary to support this proposed legislation."

A. Why could not the Administration budget anticipate the funding necessary to support such legislation?

Since the founding of the Court, I have worked with the members of Congress to make technical amendments to the Court's enabling legislation. Several technical amendments have been passed by Congress, and the Court greatly appreciates the efforts both Houses of Congress have made on the Court's behalf. The anticipated legislation that would bring the associate judges' salaries to the traditional parity level of that salary presently paid to circuit judges and the chief judge, is a remaining technical amendment that the Court understands is to be addressed by Congress. Because this legislation is not an executive branch initiative, the President's budget did not and could not include monies for the purpose of raising the associate judges' salaries to the traditional level.

The Court understood that the legislative amendment would emanate from Congress and thus that the funding attendant to the amendment would be an issue for Congress to address initially.

Two funding options are available. The first is to require the Court to absorb the costs of the increased salaries, once Congress has passed the legislation that authorizes the increases. This approach would require the Court to divert monies intended to fund the salaries of Clerk's Office personnel in the Court, thus reducing that office's staffing level and ultimately reducing the level of services the Court will be able to provide the claimants who come before the Court.

The second option is to state the Court's support for legislation it understood Congress proposed to address and to petition Congress for the necessary funding to support the legislated salary increases. This option avoids a reduction in the Court's service to the public and places the issue before Congress for its consideration.

If legislation authorizing the increase were passed today, the funding necessary to support the increase would total over $40,000, or $6,706 per judge including benefits.

B. What is the Administration's position on this legislation?

I am not aware of what position the Administration would take on the legislation, since discussions about it have occurred only with Congressional staffers. I am not in the position to speak for the Administration.

Question 2. On page 5 of the Court's budget submission, it is stated that the Court's request for FY 1991 includes the travel expenses related to the transportation of persons based on the national jurisdiction of the Court.

A. What are the Court's plans to travel for the purposes of hearing cases outside Washington, D.C., in FYs 1990 and 1991?

As the Court only recently commenced operations on October 16, 1989, it does not yet have sufficient information regarding the need to satisfy requests for hearings outside Washington, D.C.

The Court may find it advisable to hold hearings in a few population centers across the country. The Court will hear cases at other locations based on the number of requests it receives. The plan is to be able to travel when sufficient cases necessitate holding hearings outside Washington, D.C. Because it is impossible to anticipate the number of such cases, we have estimated our travel budget based on advice received from the Administrative Office of the United States Courts. We currently estimate that a panel of the Court's judges will hear cases outside of Washington, D.C. four times a year. In addition, the Court anticipates that it may be required to reimburse other United States Courts for the use of their facilities and for security support during these Court hearings.

B. What amount is included in the Court's FY 1990 appropriation and its FY 1991 budget request for such travel?

The Court's estimate for travel related to Court hearings for both FYs 1990 and 1991 is based on an estimated four hearing trips per year. It is expected that a panel of three judges and three support staff (judicial law clerks) will travel on each trip. An average trip is estimated to cost $1,400 per Court official, or roughly $8,500 per trip (6 days temporary duty, an average per diem of $150 per day, an average plane fare of $500, totalling $8,400 rounded to $8,500). The total Court expenditure for such trips is estimated at $34,000.

Question 3. A. On page 6 of the Court's budget submission, $100,000 is requested to support the operation of the Court's Admissions Committee. Please describe specifically the function of the Admissions Committee and the expenses involved in its operation, including the number of FTEE and the specific duties of the employees involved.

The Interim General Rules of the Court provide for attorneys to be admitted to the bar of the Court and for non-attorney practitioners to be admitted to practice before the Court. These representatives must meet standards of proficiency as prescribed under the Court's Interim General Rules. 38 U.S.C. § 4063(b). It is necessary to ensure that attorneys and non-attorneys are qualified to provide representation to claimants who appear before the Court and that those persons who practice before the Court understand the nature, scope and standards of the Court's legislated judicial review function. To that end, the Court envisions creating and overseeing an Admissions Committee, similar to those found in other federal, state and the District of Columbia courts.

The Admissions Committee will establish an application and examination process for those persons who desire admission to practice before the Court. It will be composed of five to seven members who will review applications from attorneys who wish admission to the bar of the Court and from non-attorneys who wish to serve as practitioners. The Committee will make recommendations to the Court on admissions and serve as a liaison between the Court and those attorneys and practitioners admitted to practice before the Court. The Committee may investigate the character, fitness and technical qualifications of those applying to practice before the Court.

The Court anticipates that the Committee will operate on an actual expense basis. Committee members will serve on the Committee on a pro bono basis. The Court expects that it will require one to one and one-half FTEEs to support the work of the Admissions Committee. Those positions will be used to: provide clerical support in receiving applications; process applications; perform preliminary clerical reviews of the applications to ensure Court standards are met; process the application fees; coordinate the issuance of certificates of admission; and provide any necessary clerical support to the Court and the Committee.

The Committee may also assist the Court in training those admitted, and in the future, in disciplinary and reciprocal disciplinary proceedings.

B. Please specify also the anticipated expenses for FY 1990 for the purposes of operating the Court's Admissions Committee.

No monies were included in the FY 1990 budget to support the work of the Admissions Committee. Because the Court expects to have the Admissions Committee in operation before the end of FY 1990, the Court intends temporarily to use the staff of the Clerk's Office to perform clerical support for the Admissions Committee. Although such an arrangement is not satisfactory, in that the Clerk's Office and the Admissions Committee are short-changed in the support each receives, the Court expects not to have any personnel dedicated solely to the Admissions Committee during FY 1990.

Question 4. A. On page 6 of the Court's budget submission, $40,000 is requested for the hiring of various expert consultants for the purpose of obtaining "certain services that cannot be performed efficiently and economically in-house." Please describe the services that require the hiring of these consultants.

In drafting its Interim General Rules, the Court received invaluable assistance from Alexander L. Stevas, Esquire, former Clerk of the United States Supreme Court. In FY 1991, the Court expects to continue to consult with Mr. Stevas on the Court's rules and the establishment of an Admissions Committee and to profit from his expertise in appellate process.

Under 38 U.S.C. § 4098(e)(1), the Chief Judge may cause periodic examination of the United States Court of Veterans Appeals Retirement Fund. The Court will require the services of an actuary both to establish the Retirement Fund and to accomplish these periodic reviews and anticipates that these services will be required on an annual basis.

The Court also will require certain computer software developmental services, including the implementation of effective networking capability for the Clerk's Office and for judges' chambers. A consultant for this purpose is already working with the Court. Roughly $1,000 has been spent for this purpose in FY 90.

We also anticipate production of a computer program that will provide retirement systems comparisons for the Court's judges, similar to those that were provided to all government employees during the Federal Employees Retirement System open season a few years ago.

The Court is studying the possibility of employing the services of a consultant to provide expertise in the area of telephone systems. It appears a significant cost savings to the Court may result from employing such a consultant. The Court is planning on using this type of service when the Court moves to its permanent location, expected to be in June of 1990. The Court also anticipates employing consultants to advise the Court on case management systems.

B. Please specify also the anticipated expenses for FY 1990 for the purposes of hiring such expert consultants.

The Court expended $7,400 in connection with consulting services associated with the drafting of the Court's Interim General Rules and expects to incur a similar expense for consulting services relating to the promulgation of additional rules and the establishment of an Admissions Committee. The Court estimates the expenses to hire the services of an actuary in FY 1990 at $15,000. The estimated expenses for computer software developmental services have been placed at $5,000 per year, although these expenses may be somewhat higher in the Court's formative years. The computer software developmental services for the United States Court of Veterans Appeals Retirement System have been estimated at $15,000, though this expense has not been included for FY 1990. The expenses related to telephone consultant services are estimated at $5,000 per year, although this figure may be initially higher in FY 1990. The case management consultant services are estimated at $5,000 in both FYs 1990 and 1991. The case management consultant services are not expected to be ongoing annual expenses.

Question 5. Also on page 6 is a request for $201,000 for "increased Court expenses that will result from the Court achieving its first full operational level." Please provide a detailed breakdown of these increased expenses.

Because the Court had not budgeted for the expenses associated with the operation of an Admissions Committee for FY 1990, the Court added $100,000 to the "Other Services" object category for FY 1991 to support the operations of that Committee.

In planning for the Court's move to permanent space, an additional $40,000 was included to cover the increased security related expenses the Court estimates it will incur in its permanent quarters. The Court's space will expand from roughly 10,000 square feet to 30,000 square feet, and the Court will be housed on multiple floors. Because of the expanded space, the Court will require additional security; we estimate needing roughly one half to one additional court security officer to handle the Court's increased security needs, arising from the move and from the increased court security needs as the cases requiring oral argument increase.

The Court estimates that an additional $61,000 will be needed to fund staff requirements for computer research access once the Court is at its full operational level. The Court anticipates a greater need for computer research once the Court's full complement of judges is appointed and the Court achieves its planned staffing level for judicial law clerks and staff attorneys.

Question 6. A. Please provide a description of the Court's current operating space, including total square footage, cost per square foot, total square footage and cost per judge and related staff, and total square footage and cost and a description of the courtroom facilities.

The Court's temporary quarters at 1625 K Street are a sanctuary of last resort. Between October 1, 1989, and February 1, 1990, the Court rented 7,500 square feet at a cost to the Court of $26.85 per square foot. In anticipation of the appointment of 4 additional judges to the Court, the Court has rented additional temporary space at the same location as of February 1, 1990. The total space now rented by the Court is 10,371 square feet at $26.85 per square foot. The total cost to the Court for this space between October 1, 1989, and September 30, 1990, will be $243,000.

The Court's temporary quarters at 1625 K Street are primitive at best. The space is designed to hold only 42 staff and has space for a very small library and file room. The average space allocated for a judge's chambers is 150 square feet, approximately the amount of space that the General Services Administration recommends for a grade 12 supervisory position. A second office of 150 square feet is available to each judge to house two judicial law clerks and one secretary. Thus, the average judge's chambers at the Court's temporary quarters will total 300 square feet for an average rental cost of $8,500 per year.

The courtroom at the Court's temporary building location totals 378 square feet for a cost of $10,149 per year. The courtroom space is barely large enough to accommodate a three-judge panel, and inadequate should the Court determine that an en banc hearing is required. Indeed, an en banc hearing has been scheduled for April of this year. It will be necessary to use the courtroom at the Court of Military Appeals for this hearing, as little to no space is available to accommodate the judges, claimants or interested parties who wish to attend hearings held in the Court's temporary facility.

B. Please provide the same information, and a schedule for activation, for the more permanent space which the Court is planning to occupy.

Based on advice received from the Administrative Office of the United States Courts and the General Services Administration, the Court's permanent space has been planned to provide a total square footage of 34,641. This space is to include office space, courtroom and library space, and conference room space. The lease for the permanent space has been appraised at $1,560,000. To this figure the General Services Administration adds what it describes as premium rate charges for certain special locations. The figures that are described below are based on my understanding of information provided by the General Services Administration and reflect that agency's adjustment to the base costs for the rental of the Court's permanent space. This cost has been estimated at a total of $1,800,000, based on the independent appraisal and the General Services Administration adjustments.

The Administrative Office of the United States Courts advised and the General Services Administration has designed the average judge's chambers to have 1,600 square feet for the judge's office; 120 square feet per judicial law clerk, and 200 square feet for a secretarial work space/reception area. The cost per square foot for office space for permanent space for the Court has been appraised at $47.02, for an estimated cost per chambers per year of $96,000. The cost for all seven judges' chambers is estimated to total $671,000. The space for the courtroom is estimated at 1,900 square feet and has been appraised at a cost per square foot of $84.64, for a total of $161,000.

According to the General Services Administration, the Court should be relocated to the permanent space by June of 1990. The Court has been advised that, as of that date, some work still may need to be performed in the courtroom area.

Question 7: How much has been spent out of the FY 1990 appropriation to the Court thus far, and what do you anticipate that total expenditures will be in FY 1990 and FY 1991 for:

A. Furnishings and decorations, including artwork, for the Court as a whole and for each judge?

To date, three judges have been appointed to the Court. No artwork has been purchased by the Court for the Court as a whole or for the judges' chambers. With the exception of the commissioning of a portrait of Congressmen Sonny (G.V.) Montgomery for the courtroom to accompany an existing portrait of Chairman Cranston which the Chairman graciously has consented to lend to the Court, the Court does not plan to purchase any artwork in FY 1990 for the Court or for the judges. Mr. Montgomery's portrait is estimated to cost $5,000. The Court plans to borrow artwork for judges' chambers from the National Gallery of Art without cost to the Court.

Because of the limited office space allotted to each judge in the temporary quarter, the Court has purchased only standard Unicor, Department of Justice (Prison Industries) office furnishings for each of the judges. The cost of these furnishings has averaged $5,000 per judge. The Court has spent $25,000, including chambers' furniture for 5 chambers, thus far in FY 1990. If the Court's remaining judges are appointed before June of 1990, the Court will spend a total of $35,000 on chambers' furnishings at the temporary quarters.

The furnishings that are being purchased for the judges' chambers while the Court continues to be located in its temporary quarters is of the standard professional type available through Unicor (Prison Industries). Once the Court relocates to its permanent quarters, the present judges' furniture will be used in support of non-judicial professional staff at the Court, and furniture will be purchased that is better suited to the rank and position of a federal judgeship. The Court understands from the Administrative Office of the United States Courts that the average cost for furnishings for a new federal appellate judge's chambers is roughly $56,000 in the first year and $6,000 in each succeeding year. The Court has no experience as to whether these figures will prove accurate once it relocates to its permanent space.

The Court has spent in FY 90 roughly $49,000 for furnishings for non-judicial personnel, and roughly $14,000 for the purchase of used law books to provide a small library while the Court is at its temporary quarters.

B. Representation and entertainment?

The Court was informed by Senate staffers that this inquiry regarding "representation" relates to Court efforts to familiarize itself with veterans' issues and the Department of Veterans Affairs' programs and benefit systems. The Court estimates its judges will undertake, on behalf of the Court, roughly one trip per month at an average cost of $1,300 per trip (including air fare and per diem). A total of $109,000, for each FY year, is the estimated amount of funds necessary to support these judicial trips.

The judges' trips will be for three purposes: to speak before various veterans' groups to inform these organizations of the role of the Court; to allow the judges to travel to various Department of Veterans Affairs' facilities to familiarize themselves with Department programs, initiatives, and facilities; and to provide for judicial appellate training and continuing legal education. Such courses will provide the Court's newer judges with the necessary training to allow them to function efficiently and effectively in their new capacity as judicial officers. The Court has not made a decision as to the number of training trips that will be necessary, as the full complement of judges has yet to be appointed.

At the time of the Court's convocation on October 16, 1989, the Court expended $3510 for a reception. The Court plans no other entertainment expenses for FYs 1990 or 1991.

THE RESPONSES OF CHIEF JUDGE FRANK Q. NEBEKER, UNITED STATES COURT OF VETERANS APPEALS, TO THE THE ONE HEARING AND THREE POST-HEARING QUESTIONS SUBMITTED BY CHAIRMAN ALAN CRANSTON, SENATE COMMITTEE ON VETERANS' AFFAIRS

The following is respectfully provided in response to the one hearing and three post-hearing questions submitted by Chairman Alan Cranston:

Question: Tendered by Senator Cranston to the Chief Judge during the hearing on February 23, 1990. Can the fees collected for admissions be used to support the funding requirements of the Court's Admissions Committee?

> 38 U.S.C. § 4085(a) indicates that the United States Court of Veterans Appeals may impose a periodic registration fee on persons admitted to practice before the Court, and the amount of the fee may not exceed $30 per year. The Court imposes a $30 registration fee on persons applying for admission to practice before the Court. To date, the Court has received approximately 20 inquiries regarding admissions to practice, but only 3 payments of the registration fee.
>
> 38 U.S.C. § 4085(b) stipulates that the "Amounts received by the Court under subsection (a) of this section shall be available to the Court for the purposes of (1) employing independent counsel to pursue disciplinary matters, and (2) defraying administrative costs for the implementation of the standards of proficiency prescribed for practice before the Court."
>
> The Court has interpreted the provisions of § 4085(b)(2) to allow it to use the monies collected in registration fees for admissions to practice to support some of the initial expenses the Court will have in establishing the standards of proficiency for practice before the Court. However, while the second clause of § 4085(b) may permit the use of the fee's for the Admissions Committee, the Court does not expect that the registration fees received will support adequately the Admissions Committee's needs in the first year as it develops the standards of proficiency, recommends the necessary policies and procedures under which background inquiries are conducted, and develops the guidelines under which these judgments are made. The $100,000 figure represents the Court's estimate of the start-up costs for establishing the Admissions Committee. The Court will reassess the monies needed to support this program in the following fiscal years, as it expects a reduced funding need once the Committee has been established.

J

Post-hearing Question 1. On page 3 of your written testimony, you state that the Court has found it difficult to employ qualified specialists in the personnel, computer, and budget fields at or near the job entry pay levels and that it is necessary to attract more experienced personnel to function efficiently.

A. What are the average salaries planned for each specialty category and how do these salaries compare with the usual Federal Government salaries and general U.S. Courts' salaries for these categories?

The average salaries planned for each specialty category are personnel specialist ($46,861 per annum, equivalent to GS-13/4), computer systems manager ($46,861 per annum, equivalent to GS-13/4), and budget/financial officer ($55,376 per annum, equivalent to GS-14/4). These salaries are consistent with those of employees holding comparable positions with similar duties and responsibilities in other United States Courts. The Court stated that it was having difficulties in employing qualified specialists for these positions at or near the job entry pay levels because applicants having the requisite experience and abilities command higher salaries. The Court believes that such applicants could still be hired within the salary range equivalent to a GS-13 or a GS-14 if the Court is prepared to offer salaries comparable to the higher steps within those grades -- up to $55,381 for the positions comparable to a grade GS-13 and up to $65,444 for the position comparable to a GS-14.

Because the Court is in the process of developing its personnel, computer, and budget/financial systems, it can ill afford to hire employees at the lower salary levels with the intention of providing on-the-job training. The Court needs to attract and employ persons with proven abilities, knowledge and skills. It is not equipped to train them and would have to rely on an undesirable method of trial and error. Thus, qualified applicants are more likely to be receiving pay in their current jobs that is at the higher levels of each of the designated job categories.

Post-hearing Question 2. In response to my pre-hearing question 2.B. regarding the travel plans of the Court, you stated that the budget submission included funds for 4 hearing trips in FY 1991. You cited, as the basis of your estimates on travel costs, an average per diem rate of $150 and an average plane fare of $500. These figures appear significantly higher than the average costs and per diem rates for government travel. Committee staff's review of the government rate for roundtrip airfare indicates that the average fare charged the government for domestic travel is $300. As for the per diem rate, federal government per diem rates average approximately $115 for major metropolitan areas. The rate for New York City, which is the highest in the continental United States, is $147.

> **A. What, then, is the basis of your figures for per diem and air fare costs?**
>
> **B. Would you please reevaluate your request for travel in light of the information above and advise the Committee of the results of that review?**

The Court's figures for per diem are based on an estimate of the actual expenses the Court's judges would incur while on temporary travel status to conduct hearings. The Court based this figure on information provided by the Administrative Office of the United States Courts, providing for the Court's judges and personnel to follow the same travel procedures and policies applied in other United States Courts. The Court continues to believe that the average estimated per diem of $150 per day more accurately reflects the subsistence and lodging expenses that will be incurred on an actual expense basis under the policies applied in other United States Courts.

Per information supplied by the Administrative Office of the United States Courts, air fare was calculated using first class accommodation averages, as allowed for federal judges under United States Court processes. However, absent medical necessity applicable to one judge, the Court's judges will not be traveling first-class, but on Government contract fares. If one accepts the figures supplied by the Committee staff (Government-wide, not United States Courts), the adjustment would be as follows: $300 per round trip flight, with the average estimated cost per trip per Court official at $1,200, or roughly $7,200 per trip (6 days temporary duty, an average per diem of $150 per day, and average plane fare of $300). Total Court expenditures for four such hearing trips would be about $30,000. If the Court concludes that more than four such hearing trips are required, the expenditures necessarily would increase. It is my belief, however, that the figures applicable to United States Courts are appropriate ones.

Post-hearing Question 3. With regard to the estimates on the cost of office space for the Court, original estimates provided to the Committee by GSA a year ago indicated that the cost per square foot should be about $20 for general office space and $30 for judges' suites. Your response to pre-hearing question 6.B. states that the cost per square foot for permanent space for the

Court has been "appraised" at $47.02 for judges' suites and law clerks' offices.

A. Who did the appraisal?

The General Services Administration has advised that the appraisal was done by an independent contractor who GSA hired to provide the figures for the rental of the building that is planned to house the Court at its permanent location. This appraisal was then utilized to develop the cost figures provided to the Committee. The Court obtained its most recent figures directly from its real estate representative at GSA.

B. The original GSA estimate for general office space was $20 per square foot. What is the appraisal now of the cost for you to obtain permanent general office space -- not including the judicial offices?

Based on the advice of the Court's real estate representative at GSA, the Court respectfully suggests that the original information on rental rates, as provided by GSA to the Committee, for general office space is incorrect. GSA has advised the Court that the average rental rates for the area of Washington in which the Court's permanent quarters is located is approximately $47.00 per square foot. GSA could not explain how the figure of $20 per square foot was provided to the Committee. The Court's real estate representative at GSA indicated that a rate of $20 per square foot is approximately what is being charged for rental space in the more distant suburbs of Washington, D.C.

The rental rate of $47.02 is the rental rate that has been appraised for the general office space for the Court at its permanent location. GSA has indicated that the judges' chambers, including the law clerks' offices, are considered as general office space, and, therefore, the estimated rental rate of $47.02 for chambers' space is the same rate charged for the general office space provided for non-judicial personnel.

C. What accounts for these very large increases from the original projections?

Because GSA has indicated that the original projection of rental rates provided to the Committee was in error, the Court believes the erroneous figure created an appearance of a large increase in rental rates. The information provided to the Court by GSA indicates that the rental rates in the Washington, D.C. area were significantly higher than $20 at the time this figure was originally provided to the Committee.

U.S. Department of Labor

Assistant Secretary for
Veterans Employment and Training
Washington, D.C. 20210

FEB 22 1990

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-8375

Dear Mr. Chairman:

As requested in your February 12 letter, enclosed are our responses to the pre-hearing questions.

I look forward to testifying before your Committee on the FY 1991 budget for veterans programs on February 23. If you need anything further prior to that time, please let me know.

Sincerely,

THOMAS E. COLLINS

Enclosures

Question 1. What was the Labor Department's original request to the Office of Management and Budget for each Veterans' Employment and Training Service budget line item?

Response:

The Department's original FY 1991 request to OMB was $2,704,000 for the National Veterans' Training Institute (NVTI), $79,076,000 for the Disabled Veterans' Outreach Program (DVOP), $72,851,000 for Local Veterans' Employment Representatives (LVER), and $17,518,000 for the Administration activity. The NVTI amount was developed from the FY 1990 appropriation of $2,600,000 and adjusted by 4% for inflation. A 5.2% inflation factor was applied to the FY 1990 DVOP/LVER total of $144,417,000.

The S&E request included two programs increases ($225,000 for the Transition Assistance Program and $200,000 to enhance the VETS' ADP capability) which are contained in the President's budget request for FY 1991. The VETS S&E request to OMB was increased to include funding for projected pay raises and other mandatory expenditures. The S&E request provides full funding for VETS' authorized staff. The other portions of the VETS budget request were reduced to reflect overall budget constraints.

Question 2. In the FY 1991 budget request, the number of National Veterans Training Institute (NVTI) participants falls to 500, from 2,199 in FY 1989 and 1,700 in FY 1990.

A. Does the 500-participant figure in the FY 1991 request reflect the expected demand for NVTI training in FY 1991?

B. How many participants would have been trained if the Department's original request to OMB for NVTI training in FY 1991 had been included in the budget?

Response:

We would like to clarify that the 2,199 referred to in the VETS request is the number of participants who received Core Curriculum training in FY 1989. The total number of all participants trained at NVTI in FY 1989 was 2,867.

A. We have defined "demand" as the minimum level of training specified in the NVTI contract - 85 course offerings serving a minimum of 2,000 students. Under the current contract signed with the University of Colorado at Denver on January 1, 1990, approximately $2.7 million (trainee travel is included in other accounts) will be needed to operate NVTI in FY 1991 at the minimum level specified in the contract. The request contemplates continuing the direction established in FY 1990 at a reduced level for FY 1991. These training priorities are core training (Professional Services Development and Veterans' Benefits) and Case Management for DVOPs and LVERs and developing several new courses: An Employment Service Management Course, Grants Management for VETS staff, and training for DVOPs and LVERs involved in the Transition Assistance Program (TAP).

B. As stated above, we had planned for at least 85 course offerings, training a minimum of 2,000 participants.

Question 3. What was the Department's original request to OMB for funding for title IV-C of the Job Training Partnership Act and how much was included in the President's budget for all programs under title IV-C and how does the proportion for veterans requested for FY 1991 out of title IV-C funds compare to that proportion in each of FY's 1988, 1989, and 1990?

Response:

Funds for Title IV-C of the Job Training Partnership Act (JTPA) are contained in the Employment and Training Administration's Training and Employment Services appropriation. The authorizing legislation specifies that the veterans program represents 5 percent of the total funds available for Title IV other than the amount for Job Corps. Based on increases in other Title IV programs related to proposed JTPA amendments, a level of $10,564,00 was requested of OMB for FY 1991. The President's Budget for 1991 includes $8,863,000 for IV-C under currently-authorized programs and $10,227,000 as a proposal for later transmittal after JTPA amendments are enacted. VETS received $10,058,000 in FY 1988, $9,517,000 in FY 1989, and $9,345,000 in FY 1990 for IV-C.

Question 4. Section 2003A of title 38, United States Code, requires the Department annually to make available to each State an amount sufficient to support one Disabled Veterans' Outreach Program Specialist (DVOP) for every 5,300 disabled and Vietnam-era veterans. Section 2004(a)(1) of title 38 requires the Department annually to make available for use in the States funds "sufficient to support the assignment of 1,600 full-time local veterans' employment representatives (LVERs) and the States' administrative expenses associated with the assignment of that number of such representatives." The President's FY 1991 budget request, however, calls for DVOP and LVER funding at levels more than 8 percent below those required by these statutory funding formulas.

A. Please explain why the President's budget does not comply with these statutory requirements.

B. How much would need to be added to the budget to provide for DVOP and LVER employment-funding levels consistent with the statutory formulas?

Response:

A. The requested level of DVOP/LVER positions is consistent with the larger national objective of budgetary constraints. It should be noted that because of the 1.4% sequestration in FY 1990, and because we were operating under continuing resolutions for most of the first quarter, we shall be able to authorize staffing of both programs at the statutory level for the remainder of FY 1990.

B. The most recent veterans population estimates indicate $6,586,000 additional funds would be needed for DVOP and $6,322,000 for LVERs.

Question 5. Section 2003A(b)(2) of title 38 provides that generally not more than three-fourths of the DVOPs in each State are to be stationed at local employment service offices. Please provide a State-by-State accounting of full- or part-time outstationed DVOPs by type of assignment. Please include a description of how this distribution complies with the requirements of section 2003A(b)(2).

Response:

The variation by State in the assignment of Disabled Veterans' Outreach Program (DVOP) Specialists to cover outstationed worksites makes a uniform accounting by State difficult. Some States report DVOP assignments by locations served and others by staff assigned outstationed responsibilities. We will provide you with a detailed accounting by State of all outstationed locations as maintained by the DVETs in each State with a comparison to the authorized by statutory levels.

Serving as the Grant Officer's Technical Representative (GOTR), the Directors for Veterans' Employment and Training (DVETs) ensure through constant monitoring that States maintain compliance with Section 2003A (b)(2) of Title 38, USC. Many States outstation 25% or more of their DVOP Specialists on a full time basis at various locations with prior concurrence with the Department of Veterans' Affairs (DVA). Other States have been granted waivers either to outstation only 20% of their allocated DVOP Specialists full time, or to ensure that no less than 20% of those DVOP Specialists are assigned some outstationed responsibilities.

Question 6. A. Please describe the current status of the Department's efforts to implement the Transition Assistance Program (TAP) under section 408 of the Veterans' Benefits Amendments Act of 1989 (Public Law 101-237) and the plans (including a timetable) for full implementation.

B. Page ASVET-17 of the Department's budget documents states that the FY 1991 request includes an increase of "$225,000 to partially fund the pilot test of [TAP]". Please explain the extent and expected effects of the shortfall and state whether it will be remedied and, if so, how.

Response:

A. Initial implementation of TAP was planned for six States and 7 pilot sites during FY 1990.

San Antonio, Texas (five bases)	Air Force
Camp Pendleton, California	Marine Corps
Denver, Colorado	Army
Jacksonville, Florida	Navy
Ft. Benning, Georgia	Army
Norfolk, Virginia (six bases)	Navy
Ft. Eustis, Virginia	Army

Coordination between DOL, DOD, DVA, State and base personnel has been completed for half the locations and the other half will be completed by March 13, 1990. The materials for the program have been developed and are being printed. Training for the TAP service providers is currently scheduled for April 1990 with the program start planned for May 1990. The evaluation plan to measure the effectiveness of the program and meet the reporting requirements of the law is being developed and will be completed by May 1990.

TAP expansion for FY 1991 is currently planned for an additional 21 sites, within the allowed 10 states, across all the military services. DOL and DOD plan to determine the FY 1991 specific locations in June 1990.

Expansion for FY 1992 and beyond would include all CONUS military bases during FY 1992 and 1993 and access to separating OCONUS personnel during FY 1993 and 1994. This expansion would be dependent upon Congressional approval of and availability of financing for the TAP pilot program and its expansion worldwide.

B. We do not have a shortfall in FY 1991 request for TAP. As we will be implementing TAP at the first pilot sites in May 1990, we do not have data to justify an all-inclusive funding request for FY 1991. We limited our request to $225,000, therefore, to cover projected automation costs. Personnel will come from the DVOP and LVER programs. Training will be provided by NVTI. The remaining operational costs will be funded from either discretionary JTPA Title IV-C funds (as we are doing in FY 1990) or from JTPA Title IV-D Pilot and Demonstration funds.

Question 7. A. How much funding is included in the FY 1991 VETS budget for automated data processing (ADP)?

B. How much was requested by the Department from OMB for ADP? C. In what way(s) can new ADP equipment be expected to improve VETS' quality of service?

Response:

A. Excluding the ADP activities relating to TAP, there is a total of $325,000 ($125,000 in Object Class 25 and $200,000 in Object Class 31) earmarked for ADP.

B. Excluding TAP, a total of $360,000 ($160,000 in Object Class 25 and $200,000 in Object Class 31) was requested.

C. In FY 1991 we will be completing a planned replacement of ADP equipment purchased prior to 1987. This is necessary to be in compliance with Departmental ADP architecture and to have all our equipment capable of operating the Veterans' Information Management System (VIMS). We believe that this plan is both cost effective and timely. It is less expensive to purchase new equipment, with greater capacity, than to repair older equipment as it begins to fail. More importantly, successful implementation of VIMS is contingent on a dependable integrated system of hardware and software. To the extent that management has more timely and more accurate information, that we anticipate will be available through VIMS, the quality of service provided will improve.

U.S. Department of Labor

Assistant Secretary for
Veterans Employment and Training
Washington D.C. 20210

March 21, 1990

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-8375

Dear Mr. Chairman:

As requested in your February 23 letter, enclosed are our responses to the post-hearing question number 2. These responses result from my testimony on February 23 before your Committee on the FY 1991 budget for veterans programs.

If you need anything further, please let me know

Sincerely,

For THOMAS E. COLLINS JHS

Enclosures

Question 2.A. For the program year ending June 30, 1989, what was the placement rate of veterans registered for employment services at local employment service offices nationwide, and how does that compare with the placement rate for non-veterans?

Response:

During July 1, 1988 - June 30, 1989 (Program Year 1988), there were 18,085,692 persons registered with Employment Service Programs. Of these, 2,335,888 were veterans, and 15,749,804 non-veterans.

During this period, 563,068 veterans were placed, and 3,230,543 non-veterans. The percentage of veterans placed to veterans registered is 24.1%, which compares to a 20.5% rate for non-veterans.

It should be noted that in periods of a robust economy such as the U.S. is now experiencing, many hard-to-place people, including hard-to-place veterans, look for jobs through the employment service system while jobs in general are easier to find. Some veterans, particularly certain disabled veterans, are in need of extra assistance to find jobs, e.g. job development and counseling. In addition, the special emphasis placed on helping veterans through DVOP and LVER staff is not fully reflected in merely compiling placement rates for veterans with that for nonveterans. Please consider that in PY 1988, while veterans made up only 12.9% of total applicants (2,335,888 out of 18,085,692), they comprised 14.9% of employment service referrals to jobs (1,112,456 out of 7,446,322), and 14.8% of total placed

(563,068 out of 3,793,611) reflecting a greater share of the effort. Thus, it is notable that through extra efforts the placement rate for veterans was higher than for nonveterans (24.1% compared to 20.5%).

Question 2.B: How do both of those figures compare with the year before?

Response:

For program year 1987 when actual LVER and DVOP staff were 90 percent of the authorized level, the percentage of veterans placed to veterans registered was 23.8%. For program year 1988 when actual LVER and DVOP staff were at 93 percent of authorized level, it was 24.1%.

For non-veterans, the percentage of those placed to registered was 20% in PY 1987, 20.5% in PY 1988.

Question 2.C: What effect would the Department's proposed 8-percent reduction in DVOPs and LVERs have on the projected placement rate for veterans and non-veterans in PY 1991?

Response:

It is not possible to accurately forecast what the placement rate for veterans would be as a result of financing DVOPs and LVERs at 92 percent of the authorized level. Of course the placement rate for nonveterans should not be affected since DVOPs and LVERs are required to provide services to veterans only.

It is expected that the volume of veteran applicants who register with the employment service will remain about the same. If the states are not able to hire and maintain LVER and DVOP staff at the level that is financed in the budget (92 percent of the authorized level) and the number of DVOP and LVER staff who serve a given number of veterans is reduced, the level of services provided will be reduced because the LVER staff, through functional supervision, affect the services provided to veterans by all LESO staff.

U.S. Department of Labor

Assistant Secretary for
Veterans Employment and Training
Washington, D.C. 20210

6 1990

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510-8375

Dear Mr. Chairman:

As requested in your February 23 letter, enclosed are our responses to the post-hearing questions.

We have also included our response to questions raised by Senator John D. Rockefeller, IV, during the February 23 hearing. Our response was also sent directly to Senator Rockefeller.

Please let me know if you need additional information.

Sincerely,

THOMAS E. COLLINS

Enclosures

RESPONSES TO POST-HEARING QUESTIONS FROM CHAIRMAN ALAN CRANSTON

Question 1. Public Law 100-689 required that VA and the Labor Department enter into a memorandum of understanding to ensure that dislocated workers who are veterans are informed of and have access to all employment and training services for which they are eligible.

A. What is the status of that memorandum?

Response:

The current Department of Veterans' Affairs (DVA)/Department of Labor (DOL) agreement was signed July 17, 1989. It contains language requiring DVA and Veterans' Employment and Training Service (VETS) personnel to identify designated responsibilities of Federal, State, and local agencies for providing information and assistance under several programs including dislocated workers under JTPA, Title III. Such coordination helps DVA and DOL ensure that veterans who are dislocated are informed of and have access to appropriate employment and training services. Further, the current agreement states that Directors for Veterans' Employment and Training will notify the DVA Regional Offices of specific JTPA activities including Title III, another provision which strengthens the required coordination. In addition, the agreement addresses coordination between employment and training deliverers, including JTPA program operations, Job Service and the DVA. Our Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) resources in Job Service regularly provide information and coordinate such assistance for veterans seeking services.

B. What resources does DOL plan to commit in FY 1991 to ensuring that such veterans are informed of and have access to such services?

Response:

Currently available resources should be sufficient to achieve the goals of P.L. 100-689. The DVOP/LVER staff will continue to coordinate with JTPA entities to maximize veterans' utilization of JTPA Title III, as indicated in the DVOP/LVER Grant Agreement. We can be encouraged by the 4.65% increase in veteran participation in Title III from PY 1987 to PY 1988; however, variations in information collection between service delivery areas may result in "soft" data. Pursuant to the passage of Public Law 100-689, DVOP specialists and LVER staff are receiving comprehensive veterans' benefits and networking training at the National Veterans' Training Institute (NVTI) in Denver, Colorado. Not only are they learning about DVA programs and services, the application of this information is also covered through workshops and case studies. "Networking" with Private Industry Councils and JTPA Service Delivery Areas are highlighted throughout the training.

Question 2. Provided under separate cover.

Question 3. Please describe the DVOP and LVER early intervention outreach efforts for those separating from the military with service-connected disabilities, and how their efforts have differed this year from last year with regard to program focus and the amount of resources allocated?

Response:

Prior to passage of Public Law 101-237, DVOP specialists provided services to individuals about to be separated due to a disability at military hospitals on an outreach basis only. In some cases, such as at Fitzsimmons Army Hospital in Colorado, DVOP specialists were outstationed at the facility to provide placement services for veterans who were receiving outpatient medical treatment and also to provide outreach to separating servicemembers who were disabled.

The Disabled Transition Assistance Program (DTAP) will consist of a four hour block of instruction jointly hosted by Department of Labor and Department of Veterans Affairs personnel. DTAP will be pilot tested at three military hospitals in FY 1990, one hospital each for the Navy (including Marine Corps), Army and Air Force where disability separations occur. In FY 1991, the DTAP pilot will be expanded to 12 additional hospitals. This will be a coordinated program between DOL, DOD, and DVA aimed at providing early intervention and comprehensive employment and training services to soon to be released disabled veterans. DOL will coordinate with the participating state to identify one Disabled Veteran Outreach Program specialist for each site to provide all applicable vocational guidance and employment and training services through their outreach efforts. Coordination with DVA and DOD has been initiated to define their support.

DTAP sites FY 1990

Texas	San Antonio	Air Force
Colorado	Fitzsimmons AH	Army
Florida	Jacksonville	Navy

Question 4. In the December 29, 1989, Federal Register, you solicited grant applications for the operation of Homeless Veterans' Reintegration Projects funded under the Stewart B. McKinney Homeless Assistance Act. Please provide the Committee with a report on the grants when they are awarded, including the locations and proposed activities.

Response:

We have had a good response to the solicitation for grant applications, with over 30 entities submitting grant applications. As soon as the grants are awarded, we will provide a report.

Question 5. In FY 1990, the funding of the National Veterans Training Institute changed from a grant to a publicly competitive contract.

A. What are the contract terms and costs?

B. Please describe whether and, if so, what ways this is a more cost-effective arrangement.

Response:

A. We completed a competitive contract process in early FY 1990. Effective January 1, 1990, VETS entered into a one-year contract with the University of Colorado at Denver (UCD) for $2.833 million. The contract has two option years which, if exercised, would cost $2.88 million in calendar year 1991 and $2.939 million in calendar year 1992.

B. There were several benefits derived from changing from a grant to a competitive contract process. First, the rigorous Requests for Proposal (RFP) associated with competitive contracts enabled VETS to evaluate both the goals and objectives of NVTI and the relationship of NVTI's mission to the agency's mission, as we strive to more effectively serve veterans. Secondly, this competitive process resulted in a much more favorable pricing of services provided through NVTI. Third, even though NVTI ultimately remained at UCD, the University has changed the organization structure of NVTI and re-evaluated its staffing pattern. Both of these actions, I believe, make NVTI a much more responsive and cost-effective entity.

Question 6. Under current law, on December 31, 1991, veterans of the Vietnam era cease to be covered as such by Chapters 41 and 42 of title 38, United States Code. Please describe the impact of this sunset provision with regard to programs and services under both chapters?

Response:

DVOP specialists, who are almost entirely disabled Vietnam-era veterans themselves, are allocated by a formula which relies heavily upon the number of Vietnam-era veterans residing in each State: "to support the appointment of one disabled veterans' outreach program specialist for each 5,300 veterans of the Vietnam era and disabled veterans residing in such State.". We estimate that there will be 2,206,000 disabled veterans as of 1991, and 8,328,000 Vietnam era veterans. After the sunset provision takes effect, the formula will require only 438 DVOP specialists to provide services, instead of our PY 1991 estimate of 1,883. For comparison purposes, we currently support 1,881 DVOP specialists. Obviously, there will be a severe reduction in outreach services.

Vietnam-era veterans will still be able to rely on Job Service to find employment as a veteran, but will no longer be given as high a priority for referral to jobs. If the sunset provision goes into effect, referral priority will become special disabled veteran, disabled veteran, veteran, eligible person and nonveteran, in that order. Further, they will not benefit from existing affirmative action mandates that currently apply to Federal contractors with contracts over $10,000 and Federal agencies.

As it relates to Transition Assistance Programs, only a fraction of DVOP specialists will remain and be available to provide separating military personnel vocational guidance, labor market, labor exchange, referral and case management services through their transition to the civilian economy. These represent services other Vietnam-era veterans have had during the last twenty or so years. This could have a negative impact on the ability of recently separated veterans to seek employment, since DVOP specialists are very active in securing employment for hard to place individuals, and private employers are more likely to hire younger, less expensive workers.

Should the sunset provision take effect, a number of veterans who served during the Vietnam era with little or no civilian work experience and remained in or reentered the military will, upon separation, still be eligible for Title II, JTPA retraining or possibly Title III services as dislocated workers after twenty years in the military. They will benefit from the TAP while still on active duty and may be eligible for JTPA IVC programs with other recently separated veterans twenty-years their junior.

While it is true that most other Vietnam-era veterans have successfully mainstreamed into the work force, those Vietnam-era veterans already in the civilian labor market who find themselves out of work at 40+ years of age could find it difficult to obtain retraining or career redirection without targeted services and availability of sufficient ombudsmen to assist them to remain productive in the civilian labor force.

This is especially true for the chronically unemployed who need the intensive job development and vocational guidance provided by the DVA and Job Service networks, through the DVOP, the VET Centers or a Vocational Rehabilitation Counselor.

Question 7. Currently, chapters 41 and 42 are based only upon a portion of the veteran community. What efforts have you made to develop a comprehensive national veterans training and employment policy for the workforce in the year 2000?

Response:

We interpret the national policy established in Chapter 41 of title 38 of the United States Code to cover all veterans. Therefore, it has been our policy to stress that Title 38, Chapter 41 provides that all veterans receive priority service in a special order of preference. All veterans, including the veteran who served between the Korean conflict and the Vietnam era is provided certain priorities at each local employment service office. Under our interpretation, and as we operate our programs, there are very few in the veterans' community that do not qualify for some employment, training, incentive or affirmative action programs.

Nevertheless, we have discussed preparing veterans for the workforce in the year 2000 at two seminars. We are continuously planning for initiatives that will be responsive to the economy, and most of all, our veterans, including aging veterans within the context of the Workforce 2000 postulates.

Question 8. Your budget documents cited a special labor force survey released by the Bureau of Labor Statistics in FY 1988 indicating that "nearly 66 percent of...Vietnam veterans who are at least 60 percent disabled are not in the labor force."

A. What does this mean with regard to how effective the DVOP and LVER programs have been?

Response:

These are veterans who served during the Vietnam Era and have been rated at 60% or more disability for compensation purposes by the Department of Veterans Affairs or by a branch of the military. They are either physically unable to return to work; or in some instances find it to be financially unfeasible to accept employment at the prospective loss of their disability compensation; or have become discouraged from attempting to return to a work environment due to past failures; or lack any significant civilian work experience in recent years. This does not mean we have given up on them, since there are some we can place. Indeed, DVOP specialists conduct outreach and often contact these disabled veterans to offer assistance. It is difficult, however, to provide them assistance unless they want to be helped. Of 129,000 Vietnam-era veterans in this category, 42,000 are in the Civilian Labor Force (41,000 counted as employed) and 87,000 are not in the labor force. While some are discouraged, or it is not practical for them to join the labor force, the mere fact that 41,000 are currently employed out of the total 129,000 Vietnam veterans with 60% or more disability status illustrates that efforts by DVOP and LVER staff, the DVA, and others, are having a positive impact on this group.

B. What plans do you have for a more successful effort to deal with the training and employment needs of disabled veterans?

Response:

To attempt yet another time to reach out and offer their services, DVOP specialists and many LVER staff are currently contacting all such disabled veterans using listings provided by the Department of Veterans' Affairs. This process was started this past November (1989). We hope they will be successful in reaching discouraged disabled Vietnam veterans and will find them suitable employment to restore their sense of dignity, pride and self esteem.

Question 9: On page 14 of the ASVET budget document, you noted that the requested funding level for the DVOP programs will provide grants to fund approximately 1,730 DVOP positions, 153 positions (8 percent) below the level prescribed by the Congressionally-mandated staffing formula. Then you said "It is unclear at this time if this reduction can be achieved in FY 1991 solely through attrition." A similar observation was made regarding the LVER reductions. What alternatives have you considered?

Response:

Since we provide funds to the States to administer the DVOP, the way in which the States staff the program with available funding is theirs to decide. If they can reach supportable staff levels through attrition, they will likely do so. If they cannot, they will ask to initiate a scale down in each such State in accordance with their own State civil-service/merit system process. This can result in a reduction-in-force that may cause the dismissal of some disabled Vietnam-era veterans serving as DVOP specialists. The extent of this cannot be estimated. In the case of LVER staff, many full-time LVER staff can be reduced to half-time before any layoff need occur. I am concerned, however, that the States, through the Interstate Conference of Employment Security Agencies, have given us an indication that they can no longer afford to absorb further reductions in funds to support formula staff levels.

I would like to think that many of the DVOP specialists that would otherwise be terminated during normal reduction-in-force procedures would be able to displace other State staff that do not have disabled veteran status. My concern is that since most are hired, and generally remain, at the entry level professional level in the SESAs, they will not be able to displace anyone in a lower level than theirs. Similarly, some LVERs may be able to use their veterans' status as a means of bumping other SESA staff with less veteran's preference. However, the bumping rights that may be exercised by DVOP and LVER staff are beyond our control and dependent upon their own employing State's civil service/ merit system rules.

Question 10: Under current OMB allocation procedures, if the grants for the State administration of the DVOP and LVER programs are less than the appropriation for these items, does the surplus go to the Treasury, become available for reprogramming, or revert to the Unemployment Trust Fund?

Response:

If the funds used for State administration of the DVOP and LVER programs are less than the appropriation for those programs, the unused portion reverts to the source of funds, the Unemployment

Trust Fund, where it remains available for subsequent appropriations.

Question 11: It is my understanding that, in the President's FY 1991 Budget, the discretionary funds for grants authorized by title 4-C of the Job Training Partnership Act were decreased by nearly half-a-million dollars, to approximately $8.9 million, and that 80 percent of that amount is already obligated to the States, leaving you with approximately $1.8 million to use at the national level, from which you not only will have to pay a large amount to supplement the funding of the National Veterans Training Institute contract that you recently signed for $2.9 million per year, but also will have to supplement the funding of the Transition Assistance Program. How much of the title 4-C funds will need to go to the Institute and the Transition Assistance Program, and how much will remain for you to distribute to special target groups and other worthy community-based projects for all of FY 1991?

Response:

At the present time substantially all of the available FY 1991 discretionary Title IV-C funds are tentatively slotted for NVTI. We are exploring the possibility of partially funding the Transition Assistance Program (TAP) using Title IV-D demonstration project funds. In any event, it is clear, that at this time, very little, if any, of the Title IV-C discretionary funds will be available for community-based projects.

Question 12: How do you anticipate using service officers of veterans service organizations in your transition program?

Response:

Public Law 101-237 provides the SESA with the authority to use veteran service organization's service officers as transition assistance workshop facilitators. Veteran service organizations have been included in briefings at the National, State and TAP site levels and have been invited to attend TAP training at NVTI.

Question 13. Tom, I am certainly glad, as I am sure you are, to see peace breaking out all over the world with potentially large accompanying U.S. troop reductions, but I am concerned about the impact that large troop reductions would have on your Transition Assistance Program training materials and quality controls. Would you report back by April 1 on what controls are possible to ensure training material uniformity and currency, and whether quality assurance safeguards can realistically be expected with such a potentially large-scale operation and small budget?

Response:

Currently, the Transition Assistance Program (TAP) pilot does not have the authority to expand or the capability of expanding to meet a potential reduction in force. We are working with the Department Of Defense (DOD) to develop resource requirements and identify resources but would also need legislative authority to expand TAP beyond the ten State pilot limit. Controls to ensure program integrity and quality control for the pilot program have been developed. Materials will be updated semi-annually and redistributed. All TAP facilitators will be trained at NVTI to ensure standardization. VETS' field staff and the military base program manager will also attend the training to monitor the delivery of TAP and assure quality and uniformity. A contract has been let to evaluate both the TAP process and the longitudinal impact of the program.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

APR 4 1990

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are the responses for the record to the prehearing questions you submitted in your letters of February 5, 9, 13, and 19, 1990.

Please let me know if we can be of further assistance.

Sincerely yours,

Edward J. Derwinski

Enclosures
EJD/map

SENATOR CRANSTON

Question: 1. Please list the date or dates on which the Secretary will transmit to Congress each of the legislative proposals described in the VA budget documents.

Answer: It is our goal to have all legislation with significant budgetary impact submitted to the Congress by the middle of March.

Question: 2. Please provide a table showing, for each account and each major activity within each account, the original FY 1991 request submitted by the Department to OMB.

Answer: The table below is the FY 1991 request submitted to OMB:

	OMB Submission	President's Request	Difference
Benefit Programs			
Compensation	$10,892,465	$11,286,856	$394,391
Pensions	3,843,000	3,762,052	-80,948
Burial Benefits	161,500	155,543	-5,957
Subtotal C&P	14,896,965	15,204,451	307,486
Readjustment Benefits	484,200	502,500	18,300
Veterans Insurance and Indemnities	15,410	15,410	...
Loan Guaranty Revolving Fund	370,600	512,200	141,600
Guaranty & Indemnity Fund *		80,800	80,800
Total Benefit Programs	15,767,175	16,315,361	548,186
Medical Programs			
Medical Care	12,631,289	12,227,066	-404,223
Medical & Prosthetic Research	216,795	198,537	-18,258
MAMOE	49,386	47,729	-1,657
Grants for the Construction of State Extended Care	42,000	42,000	...
Grants to the Republic of the Philippines	500	484	-16
Total Medical Programs	12,939,970	12,515,816	-424,154
Construction Programs			
Construction, Major Projects	750,102	530,000	-220,102
Construction, Minor Projects	193,909	145,640	-48,269
Parking Garage Revolving Fund	32,300	18,900	-13,400
Nursing Home Revolving Fund	...	-73	-73
Total Construction Programs	976,311	694,467	-281,844
General Operating Expenses & Misc.			
Veterans Benefits Administration	641,644	605,258	-36,386
National Cemetery System	59,055	54,806	-4,249
General Administration	257,687	242,450	-15,237
Total GOE	958,386	902,514	-55,872
Office of Inspector General	26,452	26,859	407
Grants for the Construction of State Veterans Cemeteries	3,717	3,946	229
Total GOE & Misc.	988,555	933,319	-55,236
Total Appropriations	$30,672,011	$30,458,963	$-213,048

* Permanent, Indefinite

NOTE: The President's Budget includes GS and SES payraise costs. These costs were not included in the OMB Budget request.

Question: 3. The FY 1990 VA budget described a proposed reorganization plan for eliminating the Office of Program Analysis and Evaluation. Has the Department reached any conclusions as to the merit of this proposal?

Answer: The transition of the VA to Department status has allowed the Department to reorganize administrative functions under six Assistant Secretaries. This revised organizational structure has placed offices with related functions under the guidance of the assistant secretaries. The primary functions of the Office of Program Analysis and Evaluation were delegated to the Assistant Secretary for Veterans Liaison and Program Coordination (program evaluations) and the Assistant Secretary for Finance and Planning (management and program planning analysis).

Question: 4. A year ago at this time, a proposal was put forward in the Independent Budget recommending that the functions of the Assistant Secretary of Labor for Veterans Employment and Training (ASVET) be transferred to the Department of Veterans Affairs. At that time, VA took no position with respect to the proposal, but promised to review it. Again this year, the Independent Budget includes a proposal to move the ASVET functions into VA. What is VA's position on this proposal?

Answer: To our knowledge, there is no specific legislative proposal on this matter pending before the Congress at this time. The Department of Veterans Affairs has no plan to initiate such a proposal. Comment on the concept would be premature.

Question: 5. If a supplemental appropriation for FY 1990 in the amount of $252.4 million were made available for medical care, how exactly would such funds be utilized (in terms of FTEE and Functions) if first made available in March, in May, or in July?

Answer: It is the Department's position that no supplemental appropriation is necessary. VA Medical Centers are planning to complete this fiscal year within the current appropriations and looking beyond this year, the budget outlook is improved and reasonably predictable compared to last year. The change from an uncertain and reduced budget outlook to a predictable and upwardly oriented budget for next year has improved employee morale and it is expected cumulative employment will exceed 192,500 and we will treat more inpatients and outpatients than in FY 1989.

Question 6. Regarding the $181 million budget authority decrease as a result of meeting Gramm-Rudman-Hollings deficit reduction targets for FY 1990, page 29-6 of the budget documents states: "It is expected these reductions will be absorbed without impacting on the delivery of medical care and veterans benefits." Please describe how this absorption took or will take place without any such impact.

Answer: Management actions have been taken to shift resources to support direct care employment and maximize workload. Community nursing home, equipment, and activations nonrecurring one-time costs have been realigned to provide for hospital and outpatient workload. In addition, VAMCs have redirected local resources into areas that will generate employment and workload.

Question: 7. Please describe the impact on the FY 1990 budget shortfall in the MAMOE account on the operations of each of the advisory committees and similar groups funded from that account.

Answer: The following nine Federally chartered advisory committees are funded from the MAMOE account. The asterisk indicates those committees which are statutory:

*Special Medical Advisory Group

*Geriatrics and Gerontology Advisory Committee

*Advisory Committee on Former Prisoners of War (managed by Veterans Benefits Administration and shared funding with VHS&RA)

*Advisory Committee on Women Veterans

*Veterans' Advisory Committee on Environmental Hazards (managed by General Counsel's office)

Advisory Committee on Health-Related Effects of Herbicides

Advisory Committee on the Readjustment Problems of Vietnam Veterans

VA Voluntary Service National Advisory Committee

Advisory Committee on Information Resource Management (in process of being established)

These nine committees had planned to have a total of 22 meetings during the fiscal year at a projected cost of $250,000. However, due to the constraints on the MAMOE budget, the total number of planned meetings was reduced to 13 at a projected cost of $175,000.

The proposed FY 1991 budget should have no adverse effect on the Federally chartered advisory committees.

Question: 8. According to page 8-12 of the budget documents, estimates for Medical Administration activities within MAMOE in FY 1990 included a $1.7 million reprogramming from the Health Professional Scholarship program. However, the reprogramming request was not approved by the Congressional Appropriations Committees.

8(A). If this reprogramming continues to be rejected for FY 1990, would you reduce your scholarship funding request for FY 1991?

Answer: No, given the projected FY 1991 funding levels, the Department will not need to request a similar transfer next year, nor will it reduce its scholarship request.

Question: 8(B). What are your revised estimates for Medical Administration activities within MAMOE, and how will you adjust to the lower-than-expected FY 1990 funding in this account?

Answer: VHS&RA is taking a number of actions to reduce on-board FTEE strength, including offering a voluntary early-out retirement opportunity for employees, maintaining a hiring freeze, and transferring 14 physicians and dentists to the field. After taking these actions into account, a $784,000 shortfall in the personal services account is projected. To avoid Reduction-in-Force and furlough procedures, the following actions to transfer from various operating accounts into personal services are being taken:

- o $125,000 from travel
- o $100,000 from consultants/contracts
- o $100,000 from MIRMO
- o $100,000 from supplies
- o $100,000 from permanent changes of station relocation costs

These transfers represent significant reductions in these accounts, and will have a major impact on MAMOE's ability to operate its programs efficiently and effectively.

Question: 9(A). What were your actual FY 1989 costs for special salary rates under the medical care account and what are your estimated costs for such rates in each of FYs 1990 and FY 1991?

Answer: The actual FY 1989 cost for special salary rates was $119.8 million. The estimated special salary rate costs for FY 1990 are $160.8 million and, for FY 1991, costs are $210.8 million.

Question: 9(B). How many facilities are paying special salary rates in FY 1990 and for which job categories are they being provided?

Answer: Almost every VA medical center has special salary rates in effect for one or more occupations. Nationally, over 50 occupations have special salary rates approved for at least one VA location. The following table is a complete listing of special salary rates by occupation, showing number of approvals in effect and the estimated number of employees covered.

NUMBER OF VHS&RA FACILITIES WITH SPECIAL
SALARY RATES AUTHORIZED UNDER 38 U.S.C. 4107(G)
AS OF 12/31/89, AND NUMBER OF EMPLOYEES COVERED

SERIES	OCCUPATION	NUMBER OF FACILITIES	ESTIMATED NUMBER EMPLOYEES COVERED
083	Police Officer/Detective	42	646
180	Psychologist	2	44
181	Rehab Tech/Alcohol	1	1
185	Social Worker	5	169
401	Biologist	3	4
403	Microbiologist	3	12
601	Blind Rehabilitation Spec	3	84
601	Cytotechnologist	2	3
601	Health Science Specialist-Perfusionist	1	1
601	Histotechnologist	3	2
601	Nuclear Med Technologist	19	53
601	Registered Respiratory Therapist	39	145
603	Physician Assistant	13	81
605	Nurse Anesthetist	54	252
610	Registered Nurse	140	18,685
610	Registered Nurse (Special Units)	11	

SERIES	OCCUPATION	NUMBER OF FACILITIES	ESTIMATED NUMBER EMPLOYEES COVERED
610	Registered Nurse (Baylor Plan)	6	
620	Licensed Practical/Voc'l Nurse	100	6,150
621	Nursing Assistant	14	2,684
630	Dietitian	5	54
631	Occupational Therapist	64	272
633	Physical Therapist	120	374
635	Corrective Therapist	1	3
636	Physical Therapy Assistant	4	20
638	Recreation Therapist	7	54
638	Creative Arts Therapist	1	3
640	Certified Respiratory Ther Tech	48	209
640	Dietetic Technician	3	19
640	Magnetic Resonance Imagent Tech	2	0
640	Echocardiograph Technician	7	8
640	Health Technician	3	10
640	Ultrasound Technician	12	13
642	Nuclear Med Technician	21	57
644	Medical Technologist	41	1,185
645	Medical Technician	13	220
646	Pathology/Histopathology/ Cytology Technician	15	43
647	Diagnostic Radiologic Tech	74	1,151
648	Therapeutic Radiologic Tech	18	40
649	Cardiac Catheterization Tech	8	20
649	Electrocardiograph Tech	3	20
649	Electroencephalograph Tech	2	13
649	Heart-Lung Machine Tech	8	7
649	Hemodialysis Tech	2	31
649	Pulmonary Function Tech	2	4
649	Medical Machine Tech	8	25
651	Respiratory Therapist	15	52
660	Pharmacist	141	2,859
661	Pharmacy Tech	21	435
665	Audio-Speech Pathologist	3	5
669	Medical Record Librarian	10	18
675	Medical Record Technician	14	110
679	Medical Clerk	10	310
681	Dental Assistant	15	160
682	Dental Hygienist	22	27
1306	Health Physicist	1	2
1310	Physicist	3	0
	TOTALS:	1,208	36,849

NOTE: In addition, an estimated 7,250 VHS&RA employees (mainly clerical, administrative, and engineering occupations) were covered by special salary rates authorized, both locally and nationally, under OPM's 5 U.S.C. Authority.

Question: 9(C). What is the range of special salary rates for each occupation category?

Answer: Since special salary rates, by law, are pegged to prevailing pay rates in the local community, there is wide variability in the rates across the country for each VA occupation. In some areas, a special rate may begin as low as step 2 of the regular statutory salary range. In very high salary areas, a special rate can begin as high as step 10 of the statutory salary range. Except for licensed physical therapists and nurse anesthetists, special salary rates may not begin at higher than the 10th step of each statutory pay grade.

Question: 9(D). What amount was/is included in the President's Budget for each of these years specifically for the purpose of covering this expense, and, to the extent that such amounts were/are not sufficient to cover the actual or estimated costs, what have been/will be the sources of funding to cover the shortfalls?

Answer: Congressional action added $45 million to the President's Budget in FY 1989 for special salary rates. No additional funds were provided by the FY 1990 Appropriation. Within the total $12.3 billion provided in the President's Budget for 1991, the VHS&RA allocated $50 million for special rates. The shortfall in previous years was funded by redirecting funding for employment, drugs, operating supplies, utilities, and "other" operating needs to support this commitment.

Question: 9(E)(i). How do the nurse and physician pay legislative initiatives affect the amount budgeted for special salary rates?

Answer: Neither the physician nor the nurse pay legislative initiatives affect the amount budgeted for special salary rates under current law. The physician special pay program is completely separate from the statutory special salary rate programs for Title 5 General Schedule and Title 38 occupations. The cost estimate for nurse pay, approximately $31 million, includes only those salary costs that are above and beyond special salary rates under the existing program.

Question: 9(E)(ii). When will that draft legislation be submitted?

Answer: The VA's draft nurse and physician pay legislative initiatives are undergoing review within the Executive Branch from the standpoint of the Administration program. We will submit these initiatives upon completion of this review and clearance.

Question: 9(E)(iii). Please explain the assumptions for the proposed nurse pay reform legislation's estimated $31 million cost and the physician pay legislation's estimated $38.6 million cost.

Answer: The Department of Veterans Affairs proposals are still undergoing Executive Branch review. Therefore, we are unable to provide a detailed cost breakdown at this time. We will be happy to do so concurrent with the delivery of our legislative proposals.

Question: 10. Your budget documents include, on page 6-57, a description of proposed legislation to authorize VA's recovery from third-party health insurers for treatment of non-service connected disabilities of service-connected veterans.

A. Please describe in detail --

(i) the assumptions that were made in order to reach the estimated $505.6 million in third party collections;

Answer: We performed an analysis of the Martinsburg W. Va. VAMC's actual experience (a successful 3rd party recovery facility) regarding billings on an inpatient basis. We then applied the Martinsburg VAMC formula to the national estimated workload of inpatients treated and took 60% of that figure as representative of our collection rate from gross billings, which resulted in a national collection goal of $394 million. The estimated impact of the new legislative proposal to bill SC veterans for their NSC conditions resulted in estimated gross billings of $187 million. We applied the 60% collection factor to that figure, then added these potential collections to the $394 million goal to arrive at the $505.6 million estimates.

Question: 10(A)(ii) the breakdown (by degree of service connection) of the anticipated recoveries;

Answer: Since the proposal only deals with treatment of illnesses not related to service-connected disabilities, this breakdown has not been developed.

Question: 10(A)(iii) the proposed collection process;

Answer: The collection process as is jointly performed by VA Medical Administration and Fiscal-Service staffs would continue to operate in the same capacity as it exists now.

Question: 10(A)(iv) the proposed methodology by which VA would determine what care that had been provided to a service-connected veteran was for the service-connected condition and what care was not, particularly in connection with care provided to veterans whose disabilities are rated at 50 percent or more.

Answer: A thorough review of each patient's medical record will be performed to determine what care, if any, was rendered for a NSC condition. This same procedure is used currently to develop billings for care furnished when there is a potential for recovery from a tort feasor, workers compensation, no-fault automobile insurance, or a crime victims' program.

Question: 10(B). Attached is a November 17, 1989, letter to me from Blue Cross/Blue Shield Association which raises the complicated issues of figuring out for what care VA should be reimbursed and of regulating access to veterans' medical and disability records. Please comment in detail on the questions raised in that letter.

Answer: This proposed expansion of VA's authority to collect from this category of veterans in no way affects their VA benefits and they will not be penalized for having or not having health insurance. The proposal simply extends VA's authority to recover the cost of providing medical care to service-connected veterans for treatment of non-service connected conditions when they have third party health insurance. We do not agree that, by instituting the billing of these veterans health insurance, premiums will increase to any measurable degree.

VA medical records do contain documentation on the disability and service connected ratings of veterans. These documents are filed in the administrative section of the medical records. They are also routinely maintained in the veteran's claims folder which is filed at VA regional offices. Administrative personnel at the medical centers have access to disability and service connected rating information. Therefore, it would not be necessary for the insurance claims reviewers to have access to the entire VA claims folder. VA medical facilities would review documentation in the medical record to determine care to be billed to the insurance company.

VA is proposing legislation to clarify its right to recover from Medicare supplemental insurance plans and to clarify the amount of an insurer's liability.

Question: 10(C). Please describe what, if any, functions involved in the preparation and collection of billings of health insurers you believe cannot be efficiently performed by a contractor's employees and explain why this is the case.

Answer: Most functions associated with the preparation and collection of bills could be performed by a contractor's employees. A major problem involves establishing the debt and getting the insurance company to agree that they are obligated to pay VA. Many insurance companies contest our authority to collect, which results in a high incidence of delinquent accounts, and requires action involving both district counsel and general counsel offices. This function, which involves interpretation of Federal statutes and regulations and VA policy, could not be delegated to a contractor. Another major problem which occurs during admission is the identification and follow-up investigation of veterans who claim that they have no insurance coverage, or who refuse to provide information regarding such coverage. It is in this labor-intensive function that use of a contractor's services could have a significant impact in increasing recoveries.

Question: 11. Is the proposed legislation to require certain veterans to make co-payments for VA care the same as was referred to in last year's budget submission?

Answer: The legislation requested in the 1991 budget requiring Category B and C veterans to make co-payments for VA outpatient and inpatient care is the same proposal that was referred to in President Bush's 1990 budget.

Question: 12(A). With regard to proposed legislation in the medical care account, please provide detailed information on how the estimates for amounts to be collected, third-party collection costs, and co-payments collected from category B and C veterans were developed.

Answer: Estimates for third party collections and co-payments from category B and C veterans were derived from statistical review and calculations based on care provided to these categories of veterans in prior fiscal years.

For the inpatient per diem charge for Category B and C veterans, it was estimated that approximately 56,387 inpatient episodes of care were attributed to Category B and C veterans and each episode had an average length of stay of 18 days. These statistics, coupled with the proposed $9 per diem charge, results in approximately $9 million in projected collections, beginning in FY 1991.

For the co-payment charge for outpatient care for Category B and C veterans of $5 and $10, respectively, it was estimated that approximately 633,000 OPT visits represented Category B veterans and 481,000 OPT visits represented Category C veterans. These statistics multiplied by the $5 and $10 co-payment results in the total projected collections for FY 1991 of $7 million.

For the co-payment for outpatient prescriptions for Category B and C veterans, it was estimated that Category B OPT veterans would total 1.6 million prescriptions and Category C OPT veterans would total 1.2

million. These totals were multiplied by $3 for Category B and $5 for Category C and would result in projected total collections for FY 1991 of $11.4 million.

Question: 12(B). Does the co-payment estimate for Category B and C veterans take into account that such veterans will be less likely to be served by VA than they have been in the past?

Answer: No. The co-payments proposed are minimal and are not expected to have a significant impact on the number of Category B and C veterans expected to use the VA system.

Question: 13. On page 6-55 of your budget books, you estimate that physician and dentist special pay will cost approximately $38.6 million in FY 1991. The cost of the recommendations in the VA "Report to the President: Adequacy of Special Pay for Physicians and Dentists" for such legislation was estimated at around $70 million.

Question: 13(A). Were the reductions achieved through selective acceptance of the recommendations or through lower dollar ceilings for each of the recommendations?

Answer: The Department of Veterans Affairs placed great reliance on the recommendations of both the Riemm Analysis Group and the VHS&RA Task Force. However, the Department's recommendations were based upon amounts which are adequate to resolve our recruitment and retention difficulties.

Question: 13(B). Please provide the detail underlying your answer to A., above.

Answer: The Department of Veterans Affairs proposal is still undergoing Executive Branch review. Therefore, we are unable to provide a detailed cost breakdown at this time. We will be happy to do so concurrent with the delivery of our legislative proposal.

Question: 14. Senior VA officials have expressed significant support for expanding outpatient services, a viewpoint that seems consistent with the trends in non-VA health care. Yet, according to page 30-38 of your budget books, obligations and budget authority for outpatient services have not increased much beyond inflation over the past three budgets. How is this funding history consistent with the expressed support for an expansion of outpatient care?

Answer: The change in the level of outpatient activity resources, like all other activities within Medical Care, will be constrained to some degree by the overall appropriation total. For instance, funds sequestered in 1990 (according to law) had to be distributed proportionately to all activities (including outpatient).

Despite this, outpatient increases 1.5 percentage points more than the total appropriation percent increase between 1989 and 1991 (almost 2.5 percentage points faster than VA hospital). During this same period outpatient staff visits are expected to increase 4 percent while VA hospital patients treated increase just 1.5 percent and census decreases 4 percent. Significant shifting did occur between 1984 and 1988 when outpatient workload increased at an average annual rate of 5.6 percent while patients treated experienced modest increases of less than one percent during the same period.

Question: 15. In order to evaluate eliminating required rotation shifts for RNs, the budget proposes an increase of 798 nurses. How does this proposal relate to VA's nurse pay reform legislative proposal?

Answer: The elimination of rotating shifts is an integral part of VA's program to improve the quality of work life for VA nurses. This budget is based on recommendations made by a VA consultant who conducted a review of pay, benefits, and working conditions in the private health care sector. The consultant's report indicated that VA needed to make pay refinements to maintain competitive salaries, but that, even with competitive salaries, VA was not providing "environmental" benefits available in the private sector. These environmental benefits, primarily related to workloads and shift assignments, are of equal and sometimes greater importance than salary to nurses making employment decisions. The report specifically stated rotating shifts may be a problem in the recruitment and retention of nurses. The requested increase in RN staff would increase VA's nurse/patient ratio and allow us to examine on a controlled basis the impact rotation shifts have on recruitment and retention of RNs.

Question: 16. Please state what the equipment backlog was at the end of 1989 and what you project the backlog to be at the end of each of FYs 1990 and 1991 under the Administration's budget proposals.

Answer: The chart below delineates the backlog for object 31 Replacement Equipment and the Non-recurring Maintenance and Repair (NRM) program. This program is under review to determine the accuracy of the backlog amounts:

(dollars in thousands)

Replacement Equipment	1989	1990	1991
Prior Year	$393,315	$497,404	$637,797
Current Requirements	250,556	258,592	266,938
Total Requirements	643,871	755,996	904,735
Request	146,467	118,199	113,210
EOY Backlog	497,404	637,797	791,525
NRM			
Prior Year	$326,185	$398,515	$509,355
Current Requirements	285,120	301,657	318,248
Total Requirements	611,305	700,172	827,603
Request	212,790	190,817	201,578
EOY	398,515	509,355	626,025

Question: 17. On page 30-72 of the VA budget documents, it is stated that the FY 1991 budget request would provide 24 FTEE and $1,725,000 for "oversight of third party collection activity from private insurers and for internal audit controls."

17(A). Please explain what portion of the FTEE and budget authority is attributable to (1) increased "internal audit controls," (2) oversight of third-party collection activity under current law, and (3) oversight of third-party collection activity under Administration-proposed legislation.

Answer: Six FTEE, requiring $325,000, will develop and maintain an aggressive program to ensure Departmental compliance with recent expanded management and reporting requirements mandated by the Financial Integrity Act and the Inspector General Act amendments of 1988. Given recent difficulties in other Departments, and OMB's call for increased emphasis on management controls, this request would provide the VA with the resources necessary to carry out a most critical program.

Regarding the third party collection activity, the legislative proposal merely establishes an account in which collections can be deposited. Eighteen FTEE are required whether legislation is enacted or not. Any changes in collection procedures can be done administratively.

These eighteen FTEE and $1.4 million will provide management, oversight, and policy required to implement and administer a third party reimbursement program. Accomplishment strategy for this initiative has two facets. In Central Office, a staff of ten will develop nationwide and individual field station annual dollar goals; and develop information, guidelines and procedures for veterans, insurance companies, and field staff to ensure an effective collection program. In addition, a field station fiscal quality assurance activity, consisting of eight FTEE will be established at the VA Finance Center in Austin, Texas. This group will visit field stations to insure compliance with policy.

Question: 17(B). Elsewhere in the budget documents (page 12-19 et seq.) it is implied that the costs of third-party collection activities should be paid from third-party collections, in order to avoid a budgetary "penalty" to VA for helping reduce the overall Government deficit by providing these funds for the general Treasury. Why does the budget not propose paying for these costs of the Office of Finance and Planning from third-party and copayment collections?

Answer: The Administration's policy is that only staff directly involved with actual development of billings and collections will be reimbursed. The traditional oversight and audit function provided by the Office of Finance and Planning personnel will be funded directly by the General Operating Expenses appropriation as is currently done for all other VA accounts.

Question: 18. What will be the specific charge to the blue-ribbon panel which is to review the Medical and Prosthetic Research Program?

Answer: This committee will address a number of aspects of the Research and Development program with the specific charge including (1) is VA's research appropriately balanced among health research subject areas? (2) is VA's research appropriate to the role of VA in providing medical and other health care services to veterans? (3) is VA's research program appropriate vis-a-vis research program of other Federal agencies, including the National Institutes of Health? and (4) What is the overall quality of VHS&RA's research program?

Question: 19. What will be the specific charge to the commission on realignment which is to review the mission of the VA health-care system?

Answer: The working title of the VA Commission on Realignment and Major Mission Change has been revised. It is now entitled the VA Commission on the Future Structure of Veterans Health Care. The new title, in a general way, focuses upon the charge to be given to the Commission -- to study the VA health care system and make appropriate recommendations about the future direction and structure of the system. For example, the Commission will analyze current medical facility missions in the context of veterans' projected needs over the next few decades. The Commission will be charged to determine whether current VA medical facility missions and programs represent optimal distribution of health care resources to veterans, and to recommend changes in distribution, if appropriate, in the current system configuration. The Commission will be instructed to make recommendations only if the proposed changes will maintain or improve quality of services to veterans.

Although this commission initiative is designed to be an independent activity, we expect it to maintain a cognizance of the special role VA health care plays in meeting veterans' continuing medical care needs. The commission will be guided to maintain a balanced approach to assure its recommendations achieve an improved system of care for eligible veterans.

Question: 20. The section of the budget documents relating to research includes the statement, on page 30-44, "Medical research supports programs involved in the treatment and diagnosis of diseases particularly relevant to the veteran."

Question: 20(A). Please indicate those research areas that are identified as most relevant to veterans.

Answer: The distribution of funding for medical research closely parallels the distribution of diagnosis of patients admitted to VA medical centers (see table below). The majority of patient problems treated in VA medical centers are in areas of heart disease, cancer, stroke, endocrine disorders, and diseases of the lung and digestive tract. These areas also account for the majority of research support. It should be emphasized that the researchers in the VA system draw their research problems from the clinical problems of the veterans patients they treat.

There are occasional opportunities in medical research that justify a special investment in a disease of particular prevalence among veteran patients. Thus, funds have been set aside in medical research in recent years for special initiatives such as support of research centers in AIDS, schizophrenia, alcoholism, and aging. Such investments, while important, must be balanced against the need to support a critical mass of researchers in medical conditions most prevalent among veteran patients.

Question: 20(B). How is this funding preference communicated to potential research applicants.

Answer: The allocation of research funding is based on scientific merit in all areas of research and closely matches principal diagnosis (see table below). The budget in recent years has been focused primarily on continued support of individual investigator initiated research as the core of the research program. It is from this infrastructure of investigators that come the preceptors for new investigators in the Career Development program, and the experience necessary for conducting cooperative studies and programs in the special research initiatives. Despite focusing the limited funding on the investigator-initiated research, on occasion there have been special opportunities for particular areas of research such as schizophrenia, AIDS and alcohol for which special solicitations have been issued by Central Office. The awarding of funding for these research areas is always based on scientific merit.

Distribution of Patients and Research Support by Diagnostic Group
FY 1988

	Diagnostic Group	% of Principal Diagnoses-Inpatient Discharge	% of All Diagnoses*	% Funding in Medical Research
1.	Infectious and parasitic diseases	1.5%	2.5%	8.0%
2.	Neoplasms	9.9%	5.4%	5.5%
3.	Endocrine, nutritional, metabolic diseases and immune disorders	2.9%	7.2%	11.6%
4.	Diseases of the Blood	0.8%	2.3%	12.7%
5.	Mental Disorders	23.1%	15.0%	13.6%
6.	Diseases of the nervous system	5.1%	5.3%	15.6%
7.	Diseases of the circulatory system	16.1%	20.9%	9.6%
8.	Diseases of the respiratory system	7.5%	7.4%	5.1%
9.	Diseases of the digestive system	8.7%	7.6%	9.2%
10.	Diseases of the genitourinary system	5.1%	4.7%	6.8%
11.	Complications of pregnancy, childbirth, and puerperium			
12.	Diseases of the musculoskeletal system and connective tissue	1.8%	1.9%	1.0%
13.	Diseases of skin and subcutaneous tissue	4.0%	3.9%	0.7%
14.	Congenital deformities	0.1%	0.2%	
15.	Ill-defined conditions	4.7%	5.4%	
16.	Injury and poisoning	3.9%	3.0%	
17.	Factors influencing health status and contact with health services	4.3%	6.5%	

(* Includes multiple diagnoses for individual patients)

Question:	21. On what basis was the estimate (on page 30-46) made that non-VA research funding -- including, in each case, from the NIH, medical care support, and other grants -- would increase by a greater proportion in FY 1991 than in each funding increased in FY 1990.
Answer:	Individual hospitals estimate that portion of their medical care funding that directly or indirectly supports the research effort. These research support funds are summed for all hospitals in the system. The projection of an increase of support dollars in FY 1991 is based on a historical trend analysis using FY 1987-1989 medical care cost center data for necessary support. The estimate of NIH and other grant support was based on trends over the last three years with the same percentage increases. The assumption was that the NIH grants to the VA would have the same percentage increase in FY 1991 as it had in the prior two fiscal years and the number of VA investigators available to compete for NIH funding would remain approximately the same.
Question:	22. For each of FYs 1989, 1990, and 1991, please provide your best estimates of funds spent, or planned to be spent, for each of the following (please also provide as to each of the items in parts A. through D., an estimate of the number of veterans treated):
Question:	22(A). PTSD programs designated pursuant to section 110(a)(1) of Public Law 110(a)(1) of Public Law 98-528.
Answer:	Public Law 98-528, Section 110(a)(1) authorized the Chief Medical Director to designate Specialized Inpatient PTSD Units (SIPUs). Sixteen of these programs have been designated since October 1984. With the FY 1989 Congressional add-on of $5 million through Public Law 100-404, funds were dedicated to the purchase of ADP equipment at a cost of $20,000 per site. In addition, three of the existing SIPUs received additional funds to support PTSD/Substance Use Disorder Programs (PSUs). VA's FY 1990 budget contains $1.695 million to support the activation of four additional SIPUs. The following chart identifies additional funds spent or planned to be spent and estimates of additional veterans treated in SIPUs for FYs 1989, 1990 and 1991:

	Units	SIPU Funding	PSU Funding	ADP Funding	Additional Workload
FY 1989	16	$155,000	$306,000	$380,000	
FY 1990	20	$1,850,000	$704,441	$100,000	370
FY 1991	20	$1,850,000	$819,774	...	620

Question: 22(B). PTSD care at inpatient VA psychiatric programs and outpatient mental health programs other than such designated PTSD programs.

Answer: The current VA information management system does not allow for the identification of the number of patients treated for PTSD on Specialized Inpatient PTSD units, nor does it provide any data on outpatient care by diagnosis. The PTSD program evaluation project begun by MH&BSS should begin to provide this kind of data after FY 1990. Also the Chief Medical Director's Special Committee on PTSD will do a one-month survey of outpatient PTSD care in September 1990 which is a followup to their 1986 survey of this area. For FY 1989, the database indicates that VA inpatient units recorded 20,397 discharges for PTSD, treating 12,750 individual veterans with the disorder. This is an increase from 18,991 PTSD discharges for 11,666 patients in FY 1988. Of the 20,297 discharges in FY 1989, 6,273 (31%) were at VAMCs with a Specialized Inpatient PTSD unit. The current VA database is not capable of identifying discharges by unit within a VAMC.

Question: 22(C). PTSD care at Vet Centers.

Answer: The amount of funds spent, or projected, for the treatment of PTSD at vet centers in FYs 1989, 1990, and 1991 is approximately $18.1 million, $18.6 million, and $18.6 million respectively. The number of veterans treated for PTSD at vet centers for FYs 1989, 1990, and 1991 is approximately 52,000 for each year indicated. (Please note that the proportion of the RCS budget spent on PTSD services was inadvertently overestimated in reference to a similar question last year. That error was discovered in preparation of the foregoing response; there has not been a decline in the level of expenditures in this year.)

Quest*ion: 22(D)(i). Contract PTSD care through non-VA providers of readjustment counseling pursuant to section 612A(e);

Answer: The amount of funds spent, or projected for contract PTSD treatment in FYs 1989, 1990, and 1991 is $3.9 million, $4.5 million and $4.5 million respectively. The number of veterans treated for PTSD through non-VA contract providers for FYs 1989, 1990, and 1991 is approximately 5,500, 6,000, and 6,000 respectively.

Question: 22(D)(ii). Mental health services provided pursuant to other authority.

Answer: In FY 1989, using appropriations provided under P. L. 100-404, 23 PTSD Clinical Teams (PCTs) were established. Total funds dispersed to these units in FY 1989 were $764,220. In FY 1990, $3,857,506 will be provided to this group of PCTs. Since PCTs are outpatient programs, the VA database does not report numbers of patients seen. This data will be collected by the MH&BSS PTSD Program Evaluation and should be available after FY 1990.

Question: 23(A)(i). What is VA's strategy for meeting the treatment needs of the 479,000 Vietnam veterans who, as estimated in the Research Triangle Institute study, have full-blown PTSD?

Answer: We intend to augment existing programs in FY 1990 by establishing four additional inpatient treatment programs for a total of 20, and by establishing 20 additional PTSD clinical teams for a total of 43 such programs. We will also emphasize the outreach efforts of our Vet Center Program and continue to stress training for VA Mental Health professionals to improve ou: treatment of this disorder.

Question: 23(A)(ii). To what extent are the resources - (both FTEE and funds) to carry out that strategy in FY 1991 included in VA's FY 1991 budget request?

Answer: Full funding for PTSD programs as expanded in FY 1990 is included in the FY 1991 request.

Question: 23(B)(i). What would be the costs of VA carrying out a program whereby in FY 1991 all reasonable outreach efforts would be made to attract all combat veterans with PTSD into VA treatment and to furnish appropriate care to all those in need of treatment?

Answer: Full funding for the workload estimate is provided in FY 1991. With the enhancements that are taking place during FY 1990 we expect the vet centers system-wide will see over [illegible],000 new Vietnam theatre veterans with PTSD. The 43 PTSD clinical teams should accomplish in excess of 140,000 outpatient visits and the 20 inpatient treatment units should provide over 25,000 episodes of inpatient care. In addition, a substantial, but unknown number of Vietnam theatre veterans suffering with PTSD will be treated at VA facilities without special units or programs.

Question: 23(B)(ii). To what extent (in funds and FTEE'S) are such costs included in VA's FY 1991 budget request?

Answer: The FY 1991 budget contains resources to continue VA PTSD treatment initiatives as enhanced in FY 1990.

Question: 24(A). Does VA's FY 1991 budget include the total $11 million increase for PTSD that Congress provided in FYs 1989 ($5 million) and 1990 ($6 million)?

Answer: Yes.

Question: 24(B)(i). Does VA's FY 1991 budget include any increase over the FY 1990 budget in funding for PTSD treatment programs?

Answer: The FY 1991 VA request for the Medical Care account is $12.3 billion, almost $1 billion over the FY 1990 level. Within this total request, PTSD treatment programs may be funded if they are consistent with the Secretary's priorities for veterans health care and are determined to be cost-effective.

Question: 24(B)(ii). If so, please describe the amount of the increase and the purposes for which the additional funds will be used.

Answer: See answer to previous question.

Question: 25. Please provide a detailed description of how the $6 million Congressional add-on for PTSD treatment activities in FY 1990, which was provided in Public Law 101-144, will be spent. Please include in the description:

Question: 25(A). The sites that have received or will receive a portion of these funds for the purposes of initiating a PTSD clinical treatment team (PCT).

Answer: Twenty new PTSD Clinical Teams (PCTS) will be funded through the $5 million provided in P.L. 101-144. Three PCTs will be located at sites suggested in the Senate Report on VA's 1990 appropriation: VAOPC Honolulu, HI; VAMC Phoenix, AZ; and VAMC Togus, ME. The other sites will be chosen from among the 60 VA medical care facilities that applied for PCT funding in FY 1989, but which were not selected at that time. Designation of these sites will be completed by April 1990.

The $500,000 specified for the National Center for PTSD (NC/PTSD is being distributed according to the request of the Executive Director of the NC/PTSD, Dr. Matthew Friedman. The $500,000 for PTSD research, evaluation and education will be used for the placement of one FTE at five of the new PCTs to assist in program evaluation. These funds will also support other evaluation activities and will support education and travel for education.

Question: 25(B). The date on which funds were or are expected to be dispersed to each site.

Answer: Funds will be dispersed to the new PCTs within two weeks of their designation, $350,000 of the funds for the NC/PTSD have already been dispersed to the NC/PTSD, and $150,000 remain in reserve pending recommendation for use by the NC/PTSD leadership (i.g. to support specific projects).

Question: 25(C). The amount of funds actually dispersed or expected to be dispersed to each of the sites for the purposes of operating the PCT during FY 1990.

Answer: Each PCT could receive up to $195,000 for its first partial year of operation. (FY 1990)

Question: 25(D). A breakdown of the funds sent to each site, including the amount allocated for each of the following:

Question: (i) salaries;

Answer: $115,500 in FY 1990; $231,000 in FY 1991

Question: (ii) the FTEE funded;

Answer: Two FTEE in FY 1990; four FTEE in FY 1991

Question: (iii) the number of months in FY 1990 for which the allocation for salaries applies:

Answer: If sites are officially designated by April 1990, the maximum number of months of operation would be six months.

Question: (iv) equipment and supplies; and

Answer: $30,000 for equipment and supplies (non-recurring funds to support activation costs). The 23 PCTs established in FY 1989 will also receive $20,000 in non-recurring funds in support of their continuing activation activities. Recurring, all other costs for all PCTs are estimated to be $1,500 in FY 1991 and beyond.

Question: (v) ADP equipment.

Answer: Non-recurring ADP costs are calculated at $50,000, to support four personal computers, two laser printers and software for the 20 new PCTs. The 23 PCTs activated in FY 1989 will also receive new ADP equipment with $25,000 per site.

Question: 25(E). The total cost, or your best estimate thereof, of supporting the 20 PCTs for that period of FY 1990 in which they will be operating and the planned uses for any portion of the $6 million that will not be used in direct support of the 20 PCTs due to delays in selecting sites, difficulties in recruiting personnel to staff the PCTS, or delays in dispersing funds to the sites.

Answer: VA has requested additional information from the 60 medical care facilities that applied for funds to activate PTSD Clinical Teams in FY 1989 and were not selected. The VA facilities were asked to respond by February 15, 1990. A task force convened in March 1990 to review and recommend 20 new PCT sites, and the recommendations will be forwarded to the Chief Medical Director for selection. Funding will be provided to the sites by April 1, 1990 as follows:

o	$2,314,000	and 40 FTEE for salaries (80 FTEE and $4,628,160 annualized).
*o	$1,080,000	non-recurring "all other" - equipment and supplies
*o	$1,600,000	non-recurring "all other" for ADP hardware and software
	$4,994,000	Total

* Some of these funds will be used to provide non-recurring "all other" and ADP support to the 23 PCTs established in FY 1989 in order to continue to assist these programs in their activation.

Of the remaining $1.0 million, $500,000 is required by the law to be used in support of the National Center for PTSD. The $500,000 specified for research, education and evaluation activities will be used in support of PCTs as follows:

o	$ 90,000	as travel funds to provide training for new PCT staff
o	$170,000	to support evaluation staff at selected PCTs.
o	$ 50,000	to support one FTEE to develop ADP software for PCT evaluation
o	$190,000	to support other evaluation efforts
	$500,000	Total

Question: 26. What will be the total funding levels for the National Center on PTSD in FYs 1990 and 1991?

Answer: The base funding for the NC/PTSD for FY 1990 and FY 1991 will be $1,960,000. It should be noted that for FY 1990, VHS&RA has provided an additional $47,000 to support necessary travel for the NC/PTSD. "Total" funding would include additional funding to support research projects (e.g. through the Merit Review process) that have not yet been determined.

Question: 27(A). What was the total number of mental-health research projects funded, or number expected to be funded in each of FY's 1989, 1990 and

1991, and what percentage is this number of the total number of non-mental-health medical research projects funded or expected to be funded in each of those years?

Answer: The number of mental health related funded and percent of total projects are listed below.

Programs	1989	1990 (est)	1991 (est)
Mental-health related	261	255	222
Non-mental-health related	1,845	1,793	1,550
Mental Health % of total non-mental health related	14.1	14.2	14.3

Question: 27(B). What was the total amount of funding provided, or expected to be provided, to mental health research projects in each of FYs 1989, 1990, and 1991, and what percentage is this amount of the total amount that was allocated in each of those years for non-mental health medical research projects?

Answer: The amount of funding for mental-health related research projects and the percentage of the total amount allocated for non-mental health medical research projects is listed below:

Programs	1989	1990 (est)	1991 (est)
Mental-health related ($000)	$22,959	$23,000	$20,000
Mental Health % of total non-mental health related	14.0	14.0	14.0

Question: 27(C). At what percentage are approved mental-health research applications (i) fully funded as compared to approved non-mental-health research applications that are fully funded and (ii) partially funded as compared to approved non-mental-health research applications that are partially funded.

Answer: The merit review board system provides for review of research proposals by the specialty board most qualified to provide such peer review. Each board assigns a priority score to each proposal it reviews. Funding is allocated based upon the priority given to the project. The same priority score level is used for determining funding for all research proposals. The mental health research programs are primarily reviewed by the Mental Health and Behavioral Science Board, although funding is also provided through Neurology Board, Career Development and other review programs. The following data summarizes results from the Mental Health and Behavioral Science merit reviews compared to all merit review boards.

Percent Success Rate*

	FY 1988	FY 1989	FY 1990
Mental Health	50.3	37.6	45.3
All Boards	48.7	35.7	41.3

* Success rate = percent of approved programs that are funded.

Funding was provided for all programs with priority 10-24 during FY 1989 and FY 1990. Programs with priorities with 10-15 receive full funding and those for 16-24 receive partial funding. Individual priority scores by boards are not readily accessible. The average priority score over the last three years has been 25.9 for MHBS and 27.4 for all boards.

Question: 28. What were the expenditures for FY 1989, and what are the proposed funding levels for the Homeless Chronically Mentally Ill program for FYs 1990 and 1991? Please include the numbers of veterans provided or to be provided care for each of FYs 1989, 1990, and 1991 and the number of project sites under each program for each year.

Answer: The following chart provides information on the number of HCMI sites, program funding and workload for FYs 1989, 1990 and 1991:

FY	HCMI Site	Funding (in millions)	Workload Pt. Assessment/	Resid. Care
1989	43	$13.252	10,000	2,500
1990	47	$15.0	14,000	2,860
1991	47	$15.0	14,000	2,860

In FY 1990, two of the four new HCMI sites will be developing programs linked to compensated work therapy initiatives for HCMI veterans with substance abuse disorders, to be funded with resources dedicated to substance abuse treatment.

At least one new HCMI program and perhaps one existing HCMI program will also be provided funds to establish drop-in/comprehensive service centers for HCMI veterans.

Existing HCMI programs may be provided additional funds to increase the number of HCMI veterans who can be placed in contract residential treatment.

Question: 29. What were the expenditures for FY 1989 and what are the proposed funding levels for the Domiciliary Care for Homeless Veterans program for FYs 1990 and 1991? Please include the number of veterans provided or to be provided care for each of FYs 1989, 1990, and 1991 and the number of project sites under each program each year.

Answer: Expenditures for the Domiciliary Care of Homeless Veterans (DCHV) program in FY 1989 equalled $10.7 million. Current budget plans call for the provision of $15 million in DCHV program support in each of fiscal years 1990 and 1991.

The number of program sites and patients treated is as follows:

FY	Number of Sites	Patients Treated
1989	20	4,711 (actual)
1990	26	5,500 (estimate)
1991	26	5,500 (estimate)

Question: 30. On page 116 of the President's budget, it is stated that the Administration is requesting $300 million for VA to provide drug treatment services in FY 1991. Please provide a detailed breakdown of this amount.

Answer:

Medical Care:	
Specialized Drug Dependence Treatment Programs	$ 105,500,000
Drug Patients Treated on Other Components of VA Health-Care System	192,200,000
Total Medical Care:	$ 297,700,000
Research:	
Continuation of Ongoing Drug Abuse Research	$ 2,300,000
TOTAL:	$ 300,000,000

Question: 31. For each of the following, please provide data separately as to alcohol abuse and drug abuse.

31(A). What were the total expenditures in each of FYs 1988 and 1989, and what are the funding levels projected for FY 1990 for VA's drug and alcohol dependence and abuse treatment programs? Please include the numbers of veterans provided or to be provided care for each of FYs 1989, 1990, and 1991 and the number of project sites under each program for each year.

Answer: The following chart (Substance Abuse Treatment Programs Resource and Workload Estimates) provides workload and cost data for specialized drug and alcohol dependence treatment programs. It should be noted that, in the latest estimate, approximately 43% of the patients treated on alcohol dependence treatment programs have mixed substance abuse problems involving both drug and alcohol. These estimates do not reflect drug treatment provided to veterans on other components of the VA system.

SUBSTANCE ABUSE TREATMENT PROGRAMS
Resource and Workload Estimates

	(dollars in thousands)			
	1988	1989	1990	1991
*** Alcohol Dependence Treatment Program:**				
Total Resources	$246,619	$210,900	$255,400	$255,400
Inpatients Treated	59,088	52,300	71,500	71,500
Number of inpatient program sites	128	123	128	128
Outpatient Visits (000)	1,075	920	1,204	1,204
Number of outpatient program sites	139	135	144	144

Drug Dependence Treatment Program:				
Total Resources	$80,767	$74,500	$90,000	$105,400
Inpatients Treated	17,249	16,429	19,252	21,737
Number of inpatient program sites	56	54	59	59
Outpatient Visits (000)	903	879	1,030	1,140
Number of outpatient program sites	66	64	66	90

* Our latest estimate is that approximately 43% of patients treated on specialized Alcohol Dependence Treatment Programs have mixed substance abuse problems involving both drugs and alcohol.

Question: 31(B). Please describe how these figures are calculated and distinguish between funds spent in direct support of specialized drug and alcohol dependence and abuse treatment programs and funds spent in other components of VA's health-care system.

Answer: FY 1988 and 1989 costs of specialized drug and alcohol dependence treatment programs presented in the Substance Abuse Treatment Programs - Resource and Workload Estimates Chart (question 31A) were based on actual costs reported by VA medical centers on VA's Cost Distribution Report (CDR). FYs 1990 and 1991 figures were estimated by adding actual CDR costs, FY 1990 program increases ($60 million) and FY 1991 VA requested budget increases ($15 million for drug dependence initiative and $487,000 for compensated work therapy/substance abuse initiative).

Estimated treatment cost and workloads for all veterans with primary or secondary drug abuse diagnoses (whether treatment was provided on specialized drug dependence treatment programs or on other bed units or outpatients clinics) are as follows:

	Fiscal Year ($ in thousands)			
	1988	1989	1990	1991
Total Treatment for Drug Diagnosed Patients	$230,560	$239,800	$269,200	$297,700
Total Patients Treated (on Specialized Treatment Programs and Other VA Components)	108,000	102,000	110,000	114,000
Total Outpatient Visits for Drug Diagnosed Patients (in 000's)	2,133	2,088	2,250	2,400

FY 1988 figures for the above chart were calculated using a per-patient cost applied to the number of veterans reported in the FY 1988 Patient Treatment File as having a primary or secondary drug abuse diagnosis. The per-patient cost was determined using Automated Management Information System (AMIS) workload data for specialized drug dependence treatment programs and CDR cost data for these programs. Outpatient costs were determined in a similar manner. 9.8 percent of all VA outpatients were considered to have a primary or secondary drug abuse diagnosis. This was inferred from the percentage of all VA inpatients having a primary or secondary drug abuse diagnosis.

FY 1989-1991 figures were calculated in a similar manner but inflation, program increases and VA budget initiatives were incorporated into the total costs.

Question: 31(C). For any amounts estimated to have been spent or to be spent on treating drug or alcohol patients in components other than drug and alcohol dependence and abuse treatment programs, please describe whether such funds were spent on treating patients for conditions other than drug or alcohol dependence or abuse disabilities.

Answer: The estimated amounts given in question 31B include:

a. Costs of treatment for substance abuse conditions provided veterans on programs other than specialized substance abuse programs (e.g., detoxification on medicine or substance abuse rehabilitation on general psychiatry).

b. Partial costs of treatment for medical, surgical and other psychiatric conditions associated with substance abuse. These services are provided to veterans on programs other than specialized substance abuse programs. Examples of such conditions would be cirrhosis of the liver, acute pancreatitis, appendicitis, post traumatic stress disorder and schizophrenia.

c. Costs of treatment for substance abuse conditions provided veterans on specialized substance abuse programs.

Question: 32(A-E). For each of FYs 1989, 1990, and 1991, please provide your best estimate of the funds spent, or planned to be spent, the number of veterans treated, or planned to be treated, and the number of sites in each of the following programs:

a. Specialized inpatient alcohol dependence treatment programs.

b. Other VA components providing inpatient alcohol treatment.

c. Outpatient alcohol dependence treatment.

d. Specialized inpatient drug dependence treatment programs.

e. Outpatient drug dependence treatment.

Answer: Please refer to the following chart (Substance Abuse Treatment Programs - Distribution by Inpatient and Outpatient).

SUBSTANCE ABUSE TREATMENT PROGRAMS
Distribution by Inpatient and Outpatient

	(dollars in thousands)		
	1989	1990	1991
* **Alcohol Dependence Treatment Program - Inpatient:**			
Resources	$196,813	$238,341	$238,341
Inpatients Treated	52,300	71,500	71,500
Number of inpatient program sites ...	123	128	128
* **Alcohol Dependence Treatment Program - Outpatient:**			
Resources	$14,087	$17,059	$17,059
Outpatients Treated	920	1,204	1,204
Number of outpatient program sites ..	135	144	144
Drug Dependence Treatment Program - Inpatient:			
Resources	$62,524	$75,529	$85,210
Inpatients Treated	16,429	19,252	21,737
Number of inpatient program sites ...	54	59	59
Drug Dependence Treatment Program - Outpatient:			
Resources	$11,976	$14,471	$20,190
Outpatients Treated	879	1,030	1,140
Number of outpatient program sites ..	64	66	90

NOTE: Data on other VA components providing inpatient alcohol treatment are unavailable.

* Our latest estimate is that approximately 43% of patients treated on specialized Alcohol Dependence Treatment Programs have mixed substance abuse problems involving both drugs and alcohol.

Question: 32(F). Halfway-house and other community-based contract care under section 620A of title 38.

	Fiscal Year		
	1989	1990	1991
Funds (in 000's)	$5,400	$7,900	$7,900
Number of placements	4,500	6,300	6,300
Number of program sites	100	110	110

Question: 33(A). What are VA's current standards for timeliness in processing claims and cases at the Regional Office (RO) and at the Board of Veterans Appeals (BVA) levels?

Answer: (BVA portion) There are no absolute standards established that would serve as a universal processing time standard for BVA actions on appeals. Given the current workload and staffing needs projections for the Board of Veterans Appeals, we have estimated that BVA response time on appeals will be approximately 175 days by the end of FY 1991.

Question: 33(B). Have these standards been changed at any time during the past three fiscal years? If so, please state why and in what ways the standards were changed.

Answer: While, as noted above, there are no absolute standards established for BVA appellate processing time, in the past the BVA has used a range of 130 to 135 days as a target figure for its response time. BVA processing time is governed largely by the number of appellate receipts. The 130 to 135 day response time target was developed prior to the passage of Pubic Law 100-687 in 1988 establishing a system of judicial review of BVA decisions. BVA appellate receipts rose in both 1988 and 1989, and we believe that the publicity associated with the establishment of judicial review has been at least partially responsible for these increased receipts. There have also been some BVA process changes that have been implemented to improve the quality of BVA decisions, and the initial adjustments to these process changes have caused BVA processing time to rise. We believe that BVA response time can be improved without injecting significant additional resources, and this response time improvement is a major initiative that is currently being pursued by the BVA.

Question: 33(A). What are VA's current standards for timeliness in processing claims and cases at the Regional Office (RO) and at the Board of Veterans' Appeals (BVA) levels?

Answer: The current (FY 1990) timeliness standards for processing claims at all Regional Offices are as follows:

COMPLETION RATES - 90 DAYS OR LESS

End Product	Standard
130	90%
150	90%
155	95%
160	89%
170	84%
190	73%
290	85%
600	78%

COMPLETION RATES - 6 MONTHS OR LESS

End Product	Standard
110	68%
120	85%
140	87%
180	87%
310	94%
320	95%

For education claims timeliness standards see the table titled Timeliness Standards.

Question: 33(B). Have these standards been changed at any time during the past three fiscal years? If so, please state why and in what ways the standards were changed.

Answer: At the beginning of each fiscal year, the overall timeliness processing standards are recomputed using the national timeliness of each measured end product area. The standards are developed by using the 12-month cumulative data reported at the end of each September. The timeliness standards for the past three fiscal years are shown on the following table.

End Product	Standard FY 1987	Standard FY 1988	Standard FY 1989
	Completion Rates 90 Days or Less		
130	92	91	88
150	91	90	89
155	NA	NA	94
160	90	88	87
170	86	84	84
190	79	75	69
290	NA	NA	85
600	NA	NA	88
	Completion Rates 6 months or less		
110	79	74	70
120	90	88	86
140	91	89	88
180	90	87	86
310	NA	NA	94
320	NA	NA	95

(Note: Where NA is used the standard did not exist.)

Prior to FY 1988, twenty-five measures of timeliness were used to assess completion of education actions. Each end product category contained multiple measures, any one of which would require a report if it fell below the minimum acceptable level of performance. While all the categories were retained as an analytical tool, only one interval carried with it a standard for reporting purposes. An interval was selected for each end product to cover 80% - 90% of the completed work. The standard in each end product was selected to reflect the expected level for 80% of the stations in order to encourage improvement in the stations ranked below the 20th percentile. It is evident that improvements in processing timeliness lead to higher standards and foster continued improvements.

TIMELINESS STANDARDS

[standards and Maximum Acceptable Level (MAL) stated as percents]

EPC	# days interval	FY 1987 MAL	FY 1988 standard	FY 1989 standard	FY 1990 standard	FY 1989 timeliness achieved
200*	0-60	75	84	84	87.7	87.7
210*	0-30	85	86	85	88.7	88.7
220*	0-90	85	90	90	92.7	92.7
230	0-60	87	90	89	91.7	91.7
240	0-90	83	91	90	93.0	93.0
250	0-180	85	93	91	92.9	92.9
260	NONE					
270	0-90	78	81	79	82.6	82.6
280	0-90	87	86	84	87.3	87.3

* These three end products represent over 95% of total education actions.

Question: 34. What additional resources (both funds and FTEEs) would be necessary in FY 1991 with respect to specific timeliness standards (in each case, please identify and describe the standard involved):

34(A). To enable the BVA to meet its standard of timeliness in deciding cases?

Answer: As previously noted, there are no absolute standards established for BVA appellate processing time. Given current workload projections and the resources requested in the President's budget for the BVA (i.e., $21,549,000 and 422 FTEE), we expect BVA response time to be approximately 175 days by the conclusion of FY 1991. In view of the fluctuations that we have seen in volume of BVA appellate receipts in recent years, we believe that the current resource request represents a prudent approach to reducing BVA processing time.

Question: 34(B). To enable the ROs to meet all VA standards of timeliness for processing compensation, pension, education, and rehabilitation claims?

Answer: We met the timeliness standards in most of the compensation and pension claims areas based on the twelve month cumulative data for FY 1989. For the areas in which we did not meet the standards, the last three current months timeliness data shows a trend of improvement. Based on the positive trend for timeliness, we feel we can reach all timeliness standards in 1991 based on our current budgeted FTEE and funding levels.

Adjudication Divisions in the regional offices collectively met all timeliness standards in FY 1989 for their processing of education claims.

The Vocation Rehabilitation and Counseling (VR&C) Divisions in the ROs administer counseling and rehabilitation programs for service-connected disabled and other eligible persons. VR&C standards are distinct from Adjudication standards. Two timeliness indicators for VR&C program participants are: (1) Time in applicant status, which measures the time from application receipt in the RO until the veteran keeps his first appointment, and (2) The time in Employment Services Case status, which measures from the time a veteran is job ready until he or she is satisfactorily employed for a period of at least 60 days. The program standard that is desired is 60 days for time in applicant status and 200 days in employment services case status. Current data indicates that these dates are 92 and 277 days respectively.

Resources to meet these standards would be represented by the addition of 73 FTEE for case management of veterans receiving services in programs of rehabilitation. This increase would allow reduction of caseloads from the current 222 cases per case manager to 190. Additionally, this would allow the reassignment of 27 FTEE counseling psychologists who are currently helping the case management effort by devoting time which would otherwise be available to accomplish direct labor counseling/evaluation service. The return of this time would impact very favorably on the applicant timeliness. The cost associated with this initiative is $2,529,000 for 1991.

Question: 35(A). What are your plans for implementing section 115 of Public Law 101-237, requiring clearly written notices of decisions which include, in any case in which a benefit sought has been denied, statements of the reasons for the decisions and summaries of the evidence considered?

Answer: We have provided our field stations with detailed instructions for implementing the law. The attached VA circular in draft form was mailed to the field stations on January 17, 1990. The final version of this circular is forthcoming. We have interpreted broadly the statute to require that notifications include the reason for the decision and a summary of the evidence considered even for cases in which benefits were partially granted. (The VA circular in draft form is retained in the committee files.)

Prior to enactment of this legislation, most denial notification letters were computer generated and released the day after a decision was processed. The system created a denial letter by selecting stock generic paragraphs. Compliance with the new notification requirements when a decision does not grant the full benefits sought eliminates use of such computer generated letters for the present.

Correspondence improvement initiatives include the addition of a word processing package on the system used for claims processing and benefit payment authorization. The package includes skeletal letters for use with free text and stock paragraphs. Basic word processing capability has already been installed and is in use at several field stations. Additional stations have been funded for installations which we anticipate will be completed by the end of FY 1990. We are reviewing our resources to determine if we can install this word processing function in the remaining regional offices by the end of FY 1990. In the interim, each regional office has the same letter package on the Wang word processing system. These letters are generally typed by a Central Transcribing Activity at each office.

Question: 35(B). What additional training has been provided, or is planned to be provided, to the employees responsible for implementing this provision?

Answer: The circular has been provided to all regional offices. It is detailed sufficiently to allow Regional Offices to train all personnel who send notices of decisions.

Question: 35(C). What plans do you have for ensuring that the quality of the notices of decisions required by section 115 will be adequate?

Answer: We recently issued implementing instructions to the field stations delineating the additional responsibilities required to provide notification to claimants. The instructions include copies of sample letters.

Under PL 101-237, we will ensure the quality of the claimant notifications just as we ensure the quality of all our correspondence. Local quality control will review a random sample of work for accuracy. This review is subject to validation both locally and at Central Office. Local management prepares semi-annually an analysis of the quality of letter writing to include findings, conclusions, and recommendations. Periodically, VACO staff conduct surveys of field station operations to observe and verify all facets of the benefits delivery system, including claimant notification.

Question: 35(D). What is your best estimate of the cost of and FTEE involved in implementing section 115 in FYs 1990 and 1991?

Answer: We already have a process for beneficiary notification. We will be including the new requirements in our existing process. Our preliminary estimate is that 145 additional FTEE would be needed to implement the claimant notification requirements of PL 101-237. We will conduct a formal work-measurement study shortly which will enable us to replace this estimate with a firm figure. In addition, preliminary estimates indicate the need for additional automated equipment to handle the increased correspondence workload. Costs of this equipment could go as high as $2 million, pending further analysis.

Question: 35E(i). Are all of these resources provided for in the FY 1990 appropriation and the FY 1991 request?

Answer: The necessary resources will be reallocated from within the FY 1990 or 1991 requests to meet the requirements of the law.

Question: 35E(ii). If not, how many additional FTEE and at what cost would be required to implement section 115 in FYs 1990 and 1991?

Answer: See 35E(i).

Question: 36. The FY 1991 budget request for VBA again raises the issue of OMB's practice in recent years of assuming automatic FTEE "savings" associated with improvements in automated data processing (ADP). One recent analysis of VA's ADP efforts ("Cost-Benefit Analysis of the Enhanced Decentralized Hospital Computer Program" (DHCP)) indicates that enhanced ADP capability does not appear to create a tangible reduction in staffing levels required to improve overall efficiency in benefits processing. Indeed, such OMB-imposed cutbacks among staffpersons responsible for implementing computer system innovations may very well offset whatever contribution improved ADP systems might otherwise make to more efficient benefits delivery.

During the course of his confirmation hearing, Chief Benefits Director-Designate D'Wayne Gray indicated his agreement, and VBA's, that imposing automatic FTEE reductions as a "savings" associated with ADP modernization is not good policy. On page 30-68 of VA's budget documents, it is stated, "Most of the [266 FTEE] reduction [in VBA] is attributable to savings generated from the short-term initiatives associated with the VBA's modernization program."

36(A). Did VA in its initial budget submission propose the 266-FTEE reduction to OMB in exchange for FY 1991 ADP modernization funding? If so, on what basis did VA make such a proposal?

Answer: The 266 FTEE reduction does not represent modernization savings only. The President's budget includes a reduction of 233 FTEE attributed to modernization savings and a net reduction of 33 FTEE associated with workload declines. The modernization savings reflected are based on implementation of the following short-term initiatives:

Initiative	Savings	Year of Implementation
Fiduciary and Field Examination Automation	16	1989
Loan Guaranty Automated Payment File	30	1989
Voucher Integration and Payment System	46	1989
Control of Veterans Records	18	1990
Integrated Target/OA Access for Outbased	19	1991
Integrated Target/OA Access for Central Office	30	1991
Loan Production System	74	1990
Total 1991 Savings	233	

All savings were supported by cost-benefit analyses developed for each initiative. The savings included in the 1991 request to OMB did not include the savings (19 FTEE) associated with the Integrated Target/OA Access for Outbased Personnel initiative. This initiative was submitted after the OMB budget was prepared.

Question: 36(B). [If not] Did VA propose the FTEE reduction as part of some other arrangement with OMB and, if so, on what basis is the proposal made?

Answer: These savings represent efficiencies from converting manual processes to automated processes. In addition, the savings are a portion of the return on the investment for allocating resources to automation. Another return on this investment is improved service delivery. The savings listed above were formulated by teams of VBA staff with program and automation expertise and represents their best estimates on how automation investments can pay for themselves. Automation is not an end to itself and therefore should only be pursued to the extent it improves service delivery or produces savings or cost avoidances (whether in operating costs or benefit costs). These figures do not represent "automatic savings" but rather a reasoned judgement by the Administration of the mix of staffing and automation necessary to provide timely and quality services to veterans, their dependents and survivors.

Question 36(C). Please provide detailed justification of the proposed cut of 266 FTEE, including a description of the results of any cost-benefit analysis supporting the reduction.

Answer: The response to question 36(A) provides a detail of the savings by project. As shown in the answer, many of the savings are for projects funded and implemented in previous years. The short-term initiatives addressed many of VBA's work processes which have been historically labor intensive. In each case, the cost-benefit analysis showed that, through automation, the amount of labor needed to perform these processes would be reduced thus generating savings.

In addition to the savings VBA reflected for the short-term initiatives, VBA's 1991 employment will decline by 33 FTEE from 1990. This reduction reflects a decline in workloads in the Support Services (118 FTEE). There is also a reduction in the Vocational Rehabilitation and Counseling Program (5 FTEE) which reflects the increase use of contractor counseling. These reductions, totaling 123 FTEE, are partially offset by increases in the Veterans Services Program (26 FTEE) to support the increased telephone activity; the Compensation, Pension and Education Program (33 FTEE) to handle the claims backlog; and the Loan Guaranty Program (31 FTEE) to continue servicing loans. The net effect of the FTEE decreases (123 FTEE) against the FTEE increases (90 FTEE) is a reduction of 33 FTEE.

Question: 37. On pages 23-121 and 23-122 of the VA budget books, it is suggested that a significant portion of the equipment inventory maintained by the National Cemetery System is in need of replacement.

37(a). What is the total replacement cost of the equipment that has been maintained by the National Cemetery System beyond its normal life expectancy and is no longer economical to maintain or is broken or unusable for any reason?

Answer: At the start of FY 1990 the total equipment backlog was $3.5 million. Through an effective maintenance program, the normal life expectancy of this equipment has already been extended by an average of 5 to 6 years and it is no longer economical to maintain.

Question: 37(b). How much additional equipment do you expect to become uneconomical to maintain or unusable in FY 1990?

Answer: An additional $3.2 million worth of equipment will require replacement during FY 1990, an estimate which is reflected in VA LOG I System reports.

Question: 37(c). What are the projected needs for replacement equipment in each of FYs 1990 and 1991 and what dollar amount of those needs is provided for in the FY 1990 appropriation and in the FY 1991 request?

Answer: In 1990 the requirements are $6.7 million of which $299 thousand are projected to be funded, leaving a backlog of $6.4 million. In 1991, an additional $2.5 million is scheduled to be replaced. The 1991 budget request provides $2.2 million, with a resulting increase of the backlog to $6.7 million.

Question: 37(d). What are the cost and other ramifications of VA's inability to meet fully its equipment replacement needs in FYs 1990 and 1991?

Answer: In a recent study, 25.8% of National Cemetery System equipment was found to have been extended an average of 5.23 years past its original replacement date. As the system's inventory of equipment becomes aged, more manhours are required for its maintenance and repair. Managers have been forced to draw from other general operating fund accounts such as supplies and materials to repair an aging fleet of equipment. Repair parts, also, become more difficult to locate and more costly to purchase as equipment ages, therefore, unexpected costs for repairs to aging and nearly worn-out equipment have made it difficult to maintain the maintenance standards that are expected at national cemeteries. It is difficult to determine the total cost impact of the inability to fund all replacement equipment needs. The impact, however, is substantial.

For example, at Calverton National Cemetery, our most active national cemetery, several major repairs ranging from $1,000 to $2,000 have been experienced. These repairs are attributed to the breakdown of old and worn parts. During the winter months, backhoes and dump trucks are operated under extreme conditions. The added stress to equipment caused by winter conditions has required frequent repairs to transmissions, rear-ends, and body parts of equipment at Calverton and other national cemeteries.

At Riverside National Cemetery, equipment repairs are similar to those at Calverton. In the first quarter of FY 1990, over $8,000 were expended toward overtime to support interment operations. Unexpected breakdowns of interment equipment crippled operations. Work crews worked overtime to meet burial needs. At one point, none of the government-owned backhoes were operational. Rental equipment was used to excavate graves. Similar experiences have been encountered in grounds maintenance operations at the Riverside facility.

Cemetery directors at Jefferson Barracks, Fort Snelling, and many other national cemeteries are having similar experiences. Steps are taken by each cemetery director to meet the needs of day-to-day burial requirements at our national cemeteries while the level of maintenance further deteriorates.

Question: 37(c): Please identify and describe the ten highest priority maintenance and repair projects that currently exist in the National Cemetery System and the estimated cost for completing each project.

Answer: The ten highest priority maintenance and repair projects are as follows:

Cemetery	Items	Estimate Cost
Ft. Snelling	Road Repairs	$100,000
Long Island	Road Repairs	90,000
Culpeper	Road Repairs	143,000
Natchez	Perimeter Wall Repairs	75,000
Ft. Bliss	Asbestos Removal	85,000
Ft. Bayard	Road Repairs	275,000
Alexandria	Exterior Stone Wall Repairs	60,000
Massachusetts	Road Repairs	170,000
Houston	Road Repairs	100,000
Salisbury	Stone Wall Repairs	120,000

The estimated cost of the ten highest priority projects totals $1,218,000. The budget request of $1,575,000 for maintenance and repair projects will fund these needs. The balance of $357,000 will be committed to other maintenance and repair needs.

Question: 38(a): What are the estimated costs in each of FYs 1990 and 1991 of implementing section 504 of Public Law 101-237, which requires VA, after January 1, 1990, to provide a graveliner for each new grave in an open National Cemetery in which remains are interred in a casket?

Answer: The total cost for graveliners as required in Public Law 101-237 is estimated at $2.7 million in 1990 and $4.1 million in 1991.

Question: 38(b): To what extent are those costs provided for in the FY 1990 appropriation and in the FY 1991 request?

Answer: The graveliner costs are fully funded in the Compensation and Pensions appropriation for 1990 and in the request for 1991.

Question: 39. Please provide a copy of VA's response to the January 19, 1990, letter from Jerry C. Conners, President of the Manufactured Housing Institute, to the Secretary concerning VA's proposal to eliminate VA-guaranteed loans for manufactured housing.

Answer: A copy of our letter to the Manufactured Housing Institute is attached.

Question: 40(A): Please describe each of the economic assumptions on which VA relied to predict (i) that the Loan Guaranty Revolving Fund will require a $512.2 million appropriation for FY 1991, and (ii) that the Guaranty and Indemnity Fund will require a $218.4 million appropriation for FY 1995.

Answer: The $512.2 million appropriation request was developed using the Loan Guaranty Budget Model which produces multi-year estimates of loan originations and foreclosures by census divisions. The model uses macroeconomic assumptions provided by Wharton Econometric Forecasting Associates (WEFA) and historical program workload data, e.g., loans outstanding, foreclosure experience, etc.

The economic assumptions used for FY 1991 were as follows:

Veterans Benefits
Administration

Washington DC 20420

Department of
Veterans Affairs

JAN 31 1990

In Reply Refer to: 264

Mr. Jerry C. Conners
President
Manufactured Housing Institute
1745 Jefferson Davis Highway
Arlington, VA 22202

Dear Mr. Conners:

This is in response to your letter to Secretary Derwinski concerning the abolishment of the VA manufactured home loan program.

I understand your concerns in this area but the recommendation to eliminate the manufactured home loan program was made after a great deal of analysis and thought. The recommendation was based on the fact that the program has experienced extremely high foreclosure rates for a long period of time with no signs of improvement. Cumulatively through FY 1989, VA has paid guaranty claims on 28.55 percent of all manufactured home loans guaranteed, compared to a 5.04 percent cumulative claim rate on site-built VA guaranteed home loans. This high claim rate has adversely affected the financial solvency of the Loan Guaranty Program and has resulted in substantial debts being established against veterans whose loans were liquidated and homes repossessed. On balance, the manufactured home loan program has not provided a viable benefit to veterans, despite our efforts over the years to improve the program. We believe the continuation of the manufactured home loan program is no longer justified.

In your letter you discuss the recent improvements made to the program in the form of higher residual income guidelines, use of a debt-to-income ratio, and imposition of a downpayment requirement. Even with those changes recent statistics indicate that the defaults and foreclosures of manufactured home loans have not lessened. The foreclosure rate for manufactured home loans originated in Fiscal Year 1987, which began October 1, 1986, the same time that the revised credit standards were effective, is 5.91 percent while the rate for site-built loans is 1.25 percent. Similarly, for Fiscal Year 1988 the foreclosure rate for manufactured home loans originated that year (some of which were subject to the downpayment requirement) is already almost one percent while the rate for site-built home loans is only 0.39 percent.

2.

Mr. Jerry C. Conners

Additionally, it appears that the number of veterans making use of the manufactured home loan program has declined significantly over the years. This does not appear to be caused solely by the changes in underwriting and the imposition of a downpayment requirement since the number of veterans obtaining VA manufactured home loans has been declining since Fiscal Year 1985, which began two years before the underwriting changes took effect and well before the downpayment requirement was imposed. The following information illustrates:

Fiscal Year	No. of Manufactured Home Loans
1984	13,110
1985	8,916
1986	6,022
1987	5,100
1988	2,071
1989	834

In summary we believe that even with changes to the program the manufactured home loan program losses have been prohibitive and based on the steadily decreasing number of veterans utilizing the program it does not appear to be cost efficient or beneficial for the VA to continue guaranteeing manufactured home loans.

If the program is abolished veterans wishing to purchase manufactured homes that are permanently affixed to the site and treated as real estate under State law will still be able to obtain VA loans through the regular home loan program. Those veterans who wish to purchase homes not eligible for our regular program will still be able to finance the purchase through the HUD program or with a conventional loan.

I hope the foregoing satisfactorily explains our position on this matter. I regret a more favorable reply is not possible.

Sincerely yours,

Keith Pedigo
Director
Loan Guaranty Service

Mortgage interest rate	10.1%
Inflation	5%
o Median Housing Price	$101,815
o Total Housing Starts	1,447.1 million
o Total U.S. Population	253.6 million
o U.S. Unemployment Rate	5.8 percent
o Subdivided by Census Divisions	

We used identical home loan originations produced from the Loan Guaranty Budget Model as the starting point for the GIF projections. However, the model cannot be used to estimate the expenses in GIF because it is designed to incorporate the number and amount of loans outstanding from previous years, the original interest rate on those loans, and the foreclosure experience to date on cohort group (fiscal year of origination), as well as other factors.

We developed a new termination rate which considers foreclosure experience from FY 1972-1988. The rate used was 6.47 percent for the first five years and 10.39 cumulative for ten years. This termination rate is higher than what was experienced in the 1970's but lower than the foreclosure experience of the 1980's. This was done to reduce the weight of the historically higher rate of foreclosures associated with the recession in 1981-82 and the recent problems in the southwestern U.S.

Question: 40(B). Please state the corresponding general assumptions on which the President's FY 1991 budget are based and explain any disparities.

Answer: The President's Budget Submission is based on a set of major economic assumptions such as annual growth of GNP, unemployment rate, rates of interest on Treasury securities, etc. The assumptions on changes in CPI are involved in projections of budgetary requirements for Compensation and Pension.

The Loan Guaranty Budget Model was specifically designed to account for the regional economic differences that impact on the GI loan housing market. The experience of the 1980's with high foreclosures, first in the midwest and Great Lakes areas and then the subsequent economic downturn in the southwestern U.S., indicated that we needed more regional data to estimate the budget requirements for the Loan Guaranty Revolving Fund. WEFA produces semi-annual economic assumptions by census region for OMB and other clients. Therefore, VA and OMB agreed to use these data for the budget model.

Question: 41. Please describe the extent of the veteran population currently eligible for direct loans under section 1811 of title 38, United States Code, and explain why VA expects to make only one such loan during each of FYs 1990 and 1991.

Answer: In 1981 the Direct Loan Program was restricted to disabled veterans obtaining Specially Adapted Housing grants who are unable to find guaranteed, or conventional loan financing. Few direct loans are being made. In fact, during FY 1989 there was only one veteran who needed direct loan financing to supplement his specially adapted grant.

Question: 42. Please expand on the description in the VA budget materials of the following proposed legislation and compare it to current law and practice: "Permission for manufactured home loan guaranty claims to be filed upon receipt of VA's resale price."

Answer: Currently, 38 U.S.C. § 1812(c)(3) prohibits VA from paying a claim under the guaranty on a manufactured home loan until after the liquidation sale. VA now provides the guaranteed loan holder with an appraisal of the value of the property. The holder must then sell the property for at least that appraised value in order to break even. If the holder sells the security for more than VA's appraised value, the holder must reduce the claim by the actual sales proceeds over and above the appraised value. If the holder sells the security for less than the appraised value, the holder may ask VA to reconsider its valuation. Such requests are often granted and have the effect of increasing the claims by the difference between the liquidation price and the appraised value.

VA will be proposing to repeal the requirement that the holder must wait until the security is liquidated before filing its claim with VA. Rather, holders would have the option of filing a claim immediately upon receipt of VA's valuation. Holders electing that option would assume the risk of loss if they are unable to sell the security property for the amount of VA's value estimate. They would also retain any profit obtained from selling the security for more than VA's valuation. Some holders, especially those who are large marketers of manufactured housing, would be willing to assume this risk in exchange for a more speedy claim payment by VA.

Holders would retain the option of using the present procedure, which provides them with some protection against further loss on the resale of the security.

Question: 43(A). Please describe what would be the effect on the VA no-bid rate of the Administration's proposal to "[i]nclude VA's losses on resale in the determination of net value."

Answer: The no-bid rate would increase to approximately 35 percent.

Question: 43(B). Under this proposal, would the amount of the theoretical losses added to VA's costs in the no-bid calculation be the same regardless of the amount of the remaining indebtedness or the appraised value of the property?

Answer: VA's estimate of losses is computed as a percent of the appraised value. The proposal would increase the percentage, and so would increase the overall estimate of loss. The loss estimate is not affected, however, by the amount of outstanding loan indebtedness, as indicated in the answer to question 43C.

Question: 43(C). Please provide representative examples of the effects of the proposed change in the no-bid formula, compared to current law, on VA's decisions whether to acquire a property in foreclosure.

Answer:

EXAMPLE 1A - SPECIFIED AMOUNT (Present law)

Total Eligible Debt	$75,000	Appraised Value	$70,000
Less: Maximum Guaranty	27,500	Less: Expenses for acquisition, management, sale, unpaid taxes, or other liens (11.45% of appraised value)	8,015
Unguaranteed Portion of Debt (Lender's risk)	$47,500	Net Value	$61,985

This case is an example of the net value of the property exceeding the unguaranteed portion of the debt. VA purchases the property for the net value ($61,985) and pays a net claim of $13,015, the difference between the total debt ($75,000) and the net value of the property ($61,985). In this case the net claim paid ($13,015) is less than the maximum claim payable ($27,500).

EXAMPLE 1B - SPECIFIED AMOUNT (Proposed law)

Total Eligible Debt	$75,000	Appraised Value	$70,000
Less: Maximum Guaranty	27,500	Less: Expenses for acquisition, management, sale, unpaid taxes, or other liens (24.54% of appraised value)	17,178
Unguaranteed Portion of Debt (Lender's risk)	$47,500	Net Value	$52,822

VA purchases the property for the net value ($52,822) and pays a net claim of $22,178, the difference between the total debt ($75,000) and the net value of the property ($52,822). In this case the net claim paid ($22,178) is still less than the maximum claim payable ($27,500).

EXAMPLE 2A - DEBT PLUS COSTS (Present law)

Total Eligible Debt	$75,000	Appraised Value	$90,000
Less: Maximum Guaranty	27,500	Less: Expenses of acquisition, etc.	10,305
Unguaranteed Portion of debt	$47,500	Net Value	$79,695

This example shows a case where the net value of the property exceeds the total eligible debt. In this case VA will purchase the property for the total debt ($75,000) and pay no claim under guaranty. There is a strong likelihood of VA making a profit on the resale of the property in this type of case.

EXAMPLE 2B - DEBT PLUS COSTS (Proposed law)

Total Eligible Debt	$75,000	Appraised Value	$90,000
Less: Maximum Guaranty	27,500	Less: Expenses of acquisition, etc.	22,086
Unguaranteed Portion of debt	$47,500	Net Value	$67,914

The case is now a specified amount. VA purchases the property for the net value ($67,914) and pays a net claim of $7,086, the difference between the total debt ($75,000) and the net value of the property ($67,914).

EXAMPLE 3A - NO AMOUNT SPECIFIED (Present law)

Total Eligible Debt	$75,000	Appraised Value	$50,000
Maximum Guaranty	27,500	Less: Estimated acquisition costs, etc.	5,725
Unguaranteed Portion of Debt	$47,500	Net Value	$44,275

In this example the unguaranteed portion of the debt ($47,500) exceeds the net value of the property ($44,275). There would be no advantage to VA in purchasing the property since this would not result in any reduction in the claim payable ($27,500).

EXAMPLE 3B - NO AMOUNT SPECIFIED (Proposed law)

Total Eligible Debt	$75,000	Appraised Value	$50,000
Maximum Guaranty	27,500	Less: Estimated acquisition costs, etc.	12,270
Unguaranteed Portion of Debt	$47,500	Net Value	$37,730

In this example the unguaranteed portion of the debt ($47,500) still exceeds the net value of the property ($37,730), and there would still be no advantage to VA in purchasing the property since this would not result in any reduction in the claim payable ($27,500).

Question: 44. Two reports of the VA Inspector General have revealed significant violations of VA underwriting rules by lenders participating in the manufactured housing program -- "Audit of Foreclosures on Automatic Loans for Mobile Homes", No. 8R3-B10-083 (July 29, 1988) and "Audit of VA's Manufactured Home Loan Program", No. 9R3-B10-101 (September 7, 1989).

44(A). What steps has VA taken to ensure that underwriting for VA-guaranteed loans for manufactured housing complies with VA requirements?

Answer: VA field stations conduct post audits on 10% of all cases to ensure that loans are being underwritten in accordance with VA standards. Where warranted, stations are expected to select additional cases from specific lenders for extra post-audits. In any case where a default is reported with three or less payments made, the quality of the underwriting is closely reviewed and documentation submitted by the lender is post-audited. Any weaknesses in underwriting are noted in a letter to the lender and recorded in the lender's file. Further investigation is made where discrepancies in income or credit information are identified.

Question: 44(B). How widespread are violations of VA underwriting standards for manufactured-housing loans and how does this compare with underwriting compliance for VA-guaranteed loans under section 1810 of title 38, United States Code.

Answer: We have no statistical data which compares violations of underwriting standards for manufactured home loans with violations of underwriting standards for loans under 38 USC 1810.

Our recommendation to eliminate the manufactured home loan program is based on the fact that VA has paid claims on 20.5 percent of all manufactured home loans, compared to a 5.0 percent rate on site-built homes.

Question: 45. Why can't the purpose VA seeks to achieve by the imposition of a downpayment requirement -- lower default rates -- be achieved by revised underwriting standards and what are you doing in this regard?

Answer: It is standard practice to require downpayments of up to 20 percent on conventional loans and it is well known in the mortgage lending industry that the foreclosure rate is lower when borrowers make a downpayment. When homeowners encounter financial difficulties, those with equity in their property are more likely to seek ways to protect their equity through foreclosure avoidance measures, including sale of the property.

VA has already taken a number of actions to improve the quality of underwriting. Over the past few years credit standards have been revised and refined to ensure the best possible underwriting. Such revisions include:

1. Establishing standard residual income guidelines by region and loan size.

2. Establishing debt-to-income ratios as an additional method of assessing risk.

3. Establishing requirements for higher level review by loan guaranty officers and written justification for loans not meeting prescribed standards.

4. Requiring pay stubs for all loan applicants (Leave and Earnings Statement for Active Duty Military Personnel) to validate income information used to qualify veterans.

5. Underwriting buydown at the note interest rate.

Question: 46(A). Please describe the budget's assumptions, for FY 1991 and the outyear projections, about whether, when, and to what extent the Government National Mortgage Association will raise its limit on VA loans in response to the increase in the maximum guaranty enacted in section 306 of the Veterans' Benefits Amendments of 1989 (Public Law 101-237). Please include a description of the assumptions in the budget about the extent of veterans' use of the increased guaranty entitlement and the effect on VA's guaranty liabilities.

Answer: In preparing the FY 1991 Budget we assumed that GNMA would accept the higher guaranteed loans in their mortgage pools within several weeks after enactment of the legislation.

We estimate the following level of additional loan activity on guaranteed loans between $144,000 and $184,000.

FY	No. Loans
1991	16,454
1992	14,634
1993	13,898
1994	13,662
1995	13,274

All these loans were included (added to the budget model projection) in the total number of loans guaranteed in GIF. Therefore, the future costs associated with foreclosures are incorporated in the budget estimates for GIF.

Question: 46(B)(i). Do VA's savings estimates for its legislative proposals relating to the loan guaranty program assume any decrease in the use or availability of VA-guaranteed loans as a result of the Administration's proposals to (a) impose a downpayment requirement, (b) increase the loan fee, or (c) eliminate fee exemptions for 10-and 20-percent disabled veterans and for survivors of veterans who died from a service-connected condition?

Answer: We did not estimate any decrease in total home loan originations due to the legislative proposals. The changes proposed to the funding fee requirements are minimal. Almost all veterans finance the funding fee. Therefore a 0.5 percent increase in the funding fee (1.25 to 1.75%) would increase the veteran's payment less than $4 a month on an average loan of $80,000.

In regard to the downpayment requirement, it is possible that some veteran borrowers who have marginal incomes and little or no savings would be precluded from immediately purchasing a home.

However, we do not believe this decline in activity would be large enough to change the budget totals. The down payment required on an average loan of $80,000 would be $2,200 or 2.75 percent. We believe veterans who do not have sufficient liquid assets could delay their purchase while saving a little more or consider less expensive housing opportunities.

Question: 46(B)(ii). If so, please describe the assumption related to each proposed modification and the cumulative effect assumed for all proposed modifications combined.

Answer: Not Applicable

Question: 46(B)(iii). If not, please provide an estimate of the decreased use or availability of VA-guaranteed loans that would result from each proposed modification and the effect of each such decrease on the budget figures for the GIF. Please include an estimate of the cumulative effects of all proposed modifications combined.

Answer: Please see response to 46(B)(i) above.

Question: 47. Section 6(c) of Public Law 100-198 requires the Secretary to report to Congress on the activities VA has carried out, through December 31, 1989, under paragraphs (4) and (5) of section 1833(a), generally limiting to 95 percent the loan-to-value ratio of vendee loans and allowing vendee loans to include an amount for property rehabilitation. The report is due March 1, 1990.

47(A). Does VA expect to comply with the statutory deadline for the report? If not, please explain the delay and state when the report will be submitted.

Answer: We expect to comply with the statutory deadline for the report. We are reviewing data regarding vendee loan down payments and amounts for property rehabilitation and will submit our report by March 1, 1990.

Question: 47(B). Section 305(a)(2) of Public Law 101-237 extended the expiration date of section 1833(a), relating to the making and sale of vendee loans, until December 31, 1990.

47(B)(i). Does VA support further extension of section 1833(a) or of any provisions thereof? Please state the reasons.

Answer: We support further extension of paragraphs (4) and (5) of section 1833(a). Our reasons for supporting the provisions will be included in the March 1990 report.

Question: 47(B)(ii). Does VA's FY 1991 budget request assume expiration of section 1833(a)?

Answer: No. For budget purposes, we assumed that this provision would be extended.

Question: 47(B)(iii). What would be the budgetary effect in FY 1991 if VA's assumption (either expiration or extension) did not occur?

Answer: 1833(a)(1) VBA's budget submission assumes that 50 percent of acquired properties would be sold with vendee loan financing. Without the provisions of 1833(a)(1), we would expect that our budget would still estimate approximately 50 percent term sales.

1833(a)(2) VBA's current policy is consistent with the provisions of 1833(a)(2), i.e., maximize cash sales to the extent this would be consistent with effective functioning of the Loan Guaranty Program. This policy would not change if 1833(a)(2) were eliminated.

1833(a)(3) Since the provisions of 1833(e) regarding the budget scoring of loan sales would remain in effect, VA would plan to sell loans in the same manner (partial recourse) as presented in the budget.

1833(a)(4) We support this provision. Therefore, there would be no change regarding the requirement for a five percent downpayment.

1833(a)(5) There would be no budgetary impact if 1833(a)(5) were eliminated. The properties involved would be sold in any event and there would be no likely difference in the incidence of foreclosure without the rehabilitation provision.

Question: 48. Section 1831(f), authorizes VA's direct-endorsement program, under which a lender may use a VA-approved appraiser chosen from a rotating list to determine the reasonable value of property for which it is making a VA-guaranteed loan. The subsection will expire on October 1, 1990.

48(A). Does the VA FY 1991 budget request assume expiration of section 1831(f)?

Answer: No. In preparing the budget, we assumed the provisions of section 1831(f) would be extended.

Question: 48(B). What would be the budgetary effect if VA's assumption (either expiration or extension) did not occur?

Answer: There is no budgetary effect if the authority for VA's direct-endorsement program is extended or not. (See response to subparagraph D below)

Question: 48(C). Does VA support extension of section 1831(f)? Why, or why not?

Answer: Yes. DVA supports extension of 1831(f) for two years in order to provide a sufficient time period to test and evaluate this program.

Question: 48(D). Section 1831(f)(2) requires VA to provide "a sufficient number of personnel" to monitor the direct- endorsement program.

48(D)(i). Describe the funds and FTEE VA has devoted in FY 1989 and will devote in each of FYs 1990 and 1991 to complying with section 1831(f)(2).

Answer: Our operating assumption in preparing the budget was that this program would be neutral in regard to FTEE resources. Specifically this means that all appraisal staff personnel that would normally be involved in reviewing appraisals and issuing CRV's (Certificates of Reasonable Value) would be needed to monitor the adequacy of the appraisals made under this program. We also intend to analyze the sufficiency of resources at field stations for this function on a regular basis to ensure appropriate compliance with section 1831(f)(2).

Question: 48(D)(ii). If resources for this function have not been fully adequate, what level of spending and staffing would be required for full compliance with section 1831(f)(2)?

Answer: Not applicable.

Question: 49. In a response to a follow-up question I asked of Chief Benefits Director-Designate D'Wayne Gray, he stated, "Phase II of the Loan Production System, which includes the LGY Index, Portfolio Loan System (PLS) Replacement, and redesign of Loan Service and Claims (LS&C) Processing, has not been funded for FY 1991; therefore, no schedule has been developed."

49(A). Was funding for these items included in the Department's budget proposal to OMB?

Answer: Yes. However, due to an incomplete assessment of cost benefits, the request was excluded from the 1991 budget and will be reviewed in the 1992 process.

Question: 49(B). How much in additional FY 1991 funding would be required to enable VA to proceed with these items in a programmatically sound manner in FY 1991?

Answer: The Department's budget submission included a total of $3.2 million for Phase II of the Loan Production System (LPS) in FY 1991. This amount included $900,000 for contractual support and $2.3 million for acquisition of equipment and software. An additional $9 million ($1 million for contractual support and $8 million for acquisitions) was estimated for FY 1992 to complete LPS, Phase II. These estimates are tentative and may require revisions pending subsequent cost/benefit analysis. Review within the Administration of this request concluded that further assessment of the costs and benefits was required. This will be completed for submission with the 1992 budget.

Question: 50(A)(i). With regard to the proposed legislation to discontinue compensation payments when the assets of incompetent veterans without dependents reach $25,000 and resume them when the estate falls to $10,000, why should veterans with mental disabilities be treated differently from veterans who have the same family situations but have physical disabilities in terms of having their compensation payments discontinued due to the size of their estates?

Answer: This legislative proposal is limited to mentally incompetent beneficiaries because the VA's Inspector General found through an audit of VA Fiduciary Program in 1987 that accumulated estates of such beneficiaries derived from VA benefits were being inherited by persons who had no original entitlement to the benefits. These estates are, for the most part, tracked through the operation of VA's Fiduciary Program. Part of the rationale behind the limitation is to reduce the funds subject to misappropriation by fiduciaries. There is no such tracking system available for the estates of competent veterans.

Question: 50(A)(ii). Please provide copies of any General Counsel's opinion(s) dealing with the constitutionality of this proposal.

Answer: No formal opinion has been issued by the General Counsel. Enclosed is a copy of a "white paper" dated March 22, 1988, prepared by an attorney in the General Counsel's office concerning the "Constitutionality of Legislation to Limit Estates of Incompetent Veterans Without Spouse, Children, or Dependent Parents." Cited therein are two cases which have upheld the constitutionality of the $1,500 limitation on the estimates of incompetent institutionalized veterans under 38 U.S.C. § 3203(b). Copies of the opinions in those cases, *United States v. Macioci*, 345 F. Supp. 325 (D.R.I. 1972), and *Ziviak v. United States*, 411 F. Supp. 416 (D. Mass. 1976), *aff'd per curiam*, 429 U.S. 801 (1974), are also enclosed for your convenience.

(Copies of the opinions are retained in the committee files.)

Question: 50(B). Please provide detailed descriptions of the criteria and the due-process procedures by which competency would be determined.

Answer: Competency is considered an issue in every case in which there is a diagnosis of a psychosis or there is other evidence which raises a question as to the beneficiary's mental capacity to manage his/her own affairs, including disbursement of funds without limitation. In the absence of clear medical evidence to the contrary, the presumption prevails that a person is competent.

When the evidence supports a *probable* conclusion of incompetency, the rating board issues a memorandum rating proposing a change in competency status. The beneficiary and his/her representative, if applicable, are provided notice of the proposed rating, the reason therefor and the right to a hearing prior to implementation of such rating. The notice includes a short resume of the facts and evidence of record that would support a finding of incompetency, an explanation of the effect of such finding on payments of VA benefits, and a statement of the right to submit evidence to show why the proposed action should not be taken, to have a hearing and to be represented.

If a request for a hearing is received within 30 days from the notification, no action is taken to make a final rating until the hearing has been held and all the evidence, including the hearing transcript, is considered. If new evidence is received within 60 days, no final action is taken until all the evidence is reconsidered. Hearings, if requested, are conducted by VA personnel who did not participate in the proposed rating of incompetency, and who will have jurisdiction over the subsequent decision. If a request for a hearing or new evidence is not received, the rating board reconsiders the issue upon the expiration of the 60 day-notice period.

The notice procedure outlined above is not used if the payee has been held incompetent by a court of jurisdiction or if a court having competent jurisdiction has appointed a guardian by reason of incompetency. Such beneficiaries are deemed to have had notice and hearing under the laws of the State.

Following completion of the notice and hearing provisions cited above, the rating board makes a formal rating as to competency citing all

MAR 22 1988

CONSTITUTIONALITY OF LEGISLATION TO LIMIT ESTATES OF INCOMPETENT VETERANS WITHOUT SPOUSE, CHILDREN, OR DEPENDENT PARENTS

The VA Office of Inspector General has, in a report entitled "Audit of Estates Maintained for Incompetent Veterans," dated May 28, 1987, indicated dissatisfaction with the inheritance of large estates, derived from VA benefits, by "remote heirs" of incompetent veterans. Such heirs are defined as relatives of incompetent veterans other than spouses, children, or dependent parents. At present, the statutory provisions relating to payment to a fiduciary on behalf of a non-hospitalized incompetent veteran, set forth in 38 U.S.C. § 3202, do not establish any ceiling on the accumulation of VA-benefit-derived funds in incompetent veterans' estates, nor do they limit the categories of persons who may inherit such funds.

There is, however, provision for escheat to the United States of funds derived from VA benefits if such funds would otherwise escheat to the State where the incompetent beneficiary had his or her last legal residence. 38 U.S.C. § 3202(e). The Inspector General audit revealed that an estimated $648 million in assets derived from VA compensation would be inherited by remote heirs under the present statutory scheme. Currently, very few funds escheat to the United States under section 3202(e), apparently because persons recognized as heirs under State law tend to appear to claim deceased incompetents' estates.

The Inspector General proposes changing the law regarding payments to fiduciaries of incompetent veterans receiving VA benefits by establishing a ceiling on the amount of such funds held by fiduciaries and by restricting inheritance of these assets to the veteran's spouse, children (regardless of age or marital status), or dependent parents. If the proposed changes are effected, the Inspector General estimates VA outlays would be reduced by about $1.9 billion over the lifetimes of the current incompetent veteran population, and approximately $1.7 billion would revert to the Federal Government.

Although no specific language has been prepared, we perceive no constitutional defect with the proposed legislative amendment. Courts have upheld the validity, under the Fifth Amendment, of 38 U.S.C. § 3203, a statute markedly similar in objective and effect to the change in law advised by the Inspector General. United States v. Macioci, 345 F. Supp. 325 (1972); Z[illegible]viak v. United States, 411 F. Supp. 416, aff'd, 429 U.S. 801 (1976). At issue in these cases was plaintiffs' argument that section 3203(b), which provides for withholding of VA pension or compensation from a government-institutionalized incompetent veteran having neither spouse nor child, when the veteran's estate equals or exceeds $1,500, violated the Fifth Amendment's Due Process Clause. It should be noted that moneys so withheld under section 3203(b) are retained by the VA upon the veteran's death, with no inheritance by remote heirs possible.

In *Macioci*, the court stated that one of the obvious purposes of title 38 of the United States Code was that "the benefits authorized therein be provided to needy veterans *and their immediate dependents*." (Emphasis supplied). 345 F. Supp. at 328. Further, the court remarked that "a corollary of this purpose is that compensation should not be paid where there is little likelihood that it will ultimately benefit an eligible veteran or his dependents." *Id.* The court then proceeded to apply a "rational justification" analysis in concluding that the classifications governing the operation of section 3203(b) were not "utterly lacking in rational justification," quoting *Flemming v. Nestor*, 363 U.S. 603, 611 (1960). The classifications were found rationally related to the purpose of title 38 that veterans' benefits be paid only for the benefit of veterans.

The *Ziviak* court adopted the reasoning and quoted much of the language of the *Macioci* opinion. Significantly, however, the court expanded the analysis to consider the background of section 3202(d) of title 38, limiting the classes of individuals who may inherit from an institutionalized incompetent veteran under slightly different circumstances, i.e., where benefits were held in a Personal Funds of Patients account at the time of death. The court interpreted the legislative history as showing that, "[C]ongress was aware of the necessity of caring for incompetent veterans and their dependents, yet concerned with the possibility that benefits might pass to persons other than the veteran or immediate dependent, thereby defeating *the major purpose of title 38*." (Emphasis supplied). 411 F. Supp. at 423. The court also underscored the "great latitude" accorded Congress in making statutory classifications in social and economic legislation" and observed that "[a] statutory discrimination will not be set aside as violative of equal protection or due process if any state of facts may be conceived to justify it," quoting *United States v. Weatherford*, 471 F.2d 42, 51 (7th Cir. 1972), *cert. denied*, 411 U.S. 972 (1973). 411 F. Supp. at 425.

More recently, the Court of Appeals for the Federal Circuit has sustained the constitutionality of statutes requiring military retirees to waive retired pay equal in amount to any VA compensation received in order to receive VA disability benefits. *Absher v. United States*, 805 F.2d 1025 (Fed. Cir. 1986), *cert. denied*, 107 S. Ct. 1953 (1987). In affirming a decision of the U.S. Claims Court, 9 Cl. Ct. 223 (1985), the Federal Circuit cited neither *Macioci* nor *Ziviak*, but applied the test that a statute must manifest "a patently arbitrary classification utterly lacking in rational justification" to fail a challenge grounded on violation of equal protection. 805 F.2d at 1026.

The handling of the equal protection issue by the courts in *Macioci*, *Ziviak*, and *Absher* is in accordance with that employed by the Supreme Court in reviewing a governmental classification not involving a fundamental constitutional right, suspect classification, or the characteristics of alienage, sex or legitimacy. Under this standard, the justices will uphold governmental classifications unless no reasonably conceivable set of facts could establish a rational relationship between the classification and an arguably legitimate end of government. J. Norak, R. Rotunda, and J. Young, *Constitutional Law* 535 (3rd ed. 1986).

In addition to the issues treated in *Macioci*, *Ziviak*, and *Absher*, above, some question has arisen regarding potential conflict between State laws establishing inheritance rights and the amendment advocated by the Inspector General. It appears that any such conflict would have to be resolved in favor of Federal legislation under the Supremacy Clause of Article Six of the Constitution. The overriding goal of Congress in seeing that VA benefits for incompetent veterans are for the purpose of caring for them and their dependents, noted in *Macioci* and *Ziviak*, clearly would preempt any interest a State might have in vindicating the entitlement of remote heirs to inherit the VA benefit-derived estate of a non-hospitalized incompetent veteran. In this regard, it is important to note that no "State's rights" challenge has been made to 38 U.S.C. § 3203(b), which would be subject to a similar complaint, since it likewise has negative impact on potential rights to inherit under State law.

In summary, no sustainable constitutional challenge to the legislative change proposed by the Inspector General appears plausible under due-process, equal-protection, or States' rights theories. Future judicial action cannot, of course, be predicted, but analogous existing precedent supports the concept.

evidence relative to the decision. The beneficiary, and his/her representative, if applicable, are advised of the decision and of the beneficiary's procedural and appellate rights. If a timely Notice of Disagreement is received, the appellate process provided for in chapter 71 of title 38, United States Code, is initiated, including, ultimately, the right to appeal the decision to the Court of Veterans Appeals under chapter 72.

Question: 50(C). Since the purpose of the proposal, as stated on page 1-8 of VA budget documents, is to "assure that remote relatives of incompetent veterans do not inherit large sums of veterans benefits," why is no exception proposed for, for example, non-dependent parents and for brothers and sisters?

Answer: The proposed legislation is patterned, to some extent, after existing legislation contained in 38 U.S.C. §3203(b)(1)(A). The Congress has set the example by already excluding classes of non-dependent persons from consideration. Additionally, the court has stated that one of the obvious purposes of title 38 of the USC was that "the benefits authorized therein be provided to needy veterans and their immediate dependents." (Emphasis supplied). Please see the attached white paper, answer 50.A.(ii).

Question: 50(D). Why is no exception proposed for these and other relatives who are not dependents but provided substantial emotional or other support to the veteran?

Answer: The response to sub-part (C) above would have to be reiterated in part to the response to this question. Additionally, it would be almost impossible to make an objective determination as to at what point emotional or other support would warrant the inclusion of some other potential heir to the exemptions for subjecting a veteran to the proposed legislation. Each case would need to be evaluated from a subjective viewpoint. Undoubtedly, such subjective evaluations would be seen as being arbitrary and capricious. The amount of litigation to come out of that process cannot be estimated. More significant, however, is that even if we were to include an exception for such individuals, there is no guarantee that the targeted individuals would inherit the veteran's estate. Since most incompetent veterans do not have wills, their estates are distributed according to the state intestacy laws.

Question: 50(E). Why should disability payments for a non-institutionalized veteran with an appointed fiduciary but no dependents be discontinued because of the size of an estate that may have been derived in substantial part from other-than-VA sources, such as an inheritance, or may be in a non-liquid form, such as real estate, and not readily accessible for daily living expenses?

Answer: The issue is not the source of the estate, but the size of the estate needed to provide adequate care and maintenance. In September 1980 a letter was sent from the former Chairman of the House Committee on Veterans' Affairs to the Comptroller General of the United States requesting an audit to determine the extent that incompetent veterans' estates held by fiduciaries would revert to remote heirs. This letter stated, "...Congress intended that distant relatives should not be enriched through benefits intended for veterans or their immediate families." It is with this intent in mind that this legislation has been proposed. This proposal does include an exclusion for the veteran's personal residence and effects.

Question: 50(F). What control system would be used to monitor estate values to ensure timely discontinuance and resumption of benefit payments?

Answer: VA does not foresee the need to materially alter the way estates are currently monitored for the $1,500 rule (38 U.S.C. §3203(b)(1)(A)). Federally appointed fiduciaries in large estate cases are required to account on an annual basis. Court-appointed fiduciaries are required to account according to the period defined by State statutes, annually in most cases, but no less frequently than triennially.

Question: 50(G). What additional responsibilities, translated into workload and FTEE, would be required to implement the proposed legislation?

Answer: Our projections indicate that the workload for account audits is expected to increase by about 8,600, requiring 30 additional estate analysts at the current production rates. Field examination workload is expected to increase by 6,000 to 8,000 in one year. Workload will be carefully monitored and, if additional resources are needed, they will be requested in future budget proposals where they can be considered within the overall context of total requirements.

Question: 50(H). If additional personnel would be required, from what activity would they be diverted, what would be their cost, and why are they not shown in the budget?

Answer: Any additional workload that might be generated by passage of this proposal will be absorbed for the first year of implementation. Workload will be carefully monitored and, if additional resources are needed, they will be requested in future budget proposals where they can be considered within the overall context of total requirements.

Question: 50(I)(i). Would all benefits withheld because of incompetency and lack of dependents be repaid in a lump sum upon a finding of competency on the part of the veteran or the veteran's acquiring a spouse, child, or dependent parent?

Answer: If the incompetent veteran acquires a spouse, child, or dependent parent while benefits are being withheld, future payments would be restored under the proposal. Only past benefits withheld would not be restored as long as the veteran remained incompetent. We believe the number of incompetent veterans whose past benefits would be so affected would be very small.

Question: 50(I)(ii). If so, in the estimate of savings, what total amount of such repayments were estimated to occur in each of FYs 1991 through 1995?

Answer: We have no estimate for the amount of money to be released upon restoration to competency. Our experience is that a very small percentage of those rated incompetent are rehabilitated to the point of restoration. Restoration is a point that is evaluated closely during the VBA's supervision of incompetency cases.

Question: 50(I)(iii). If not, wouldn't it be inconsistent with the purpose of the proposal -- preventing remote relatives of incompetent veterans from inheriting large sums of veterans benefits -- for the withheld amounts not to be restored?

Answer: Not applicable. Please see answer to 50(I)(i).

Question: 50(J)(i). Did this proposed legislation originate within the VA or at OMB?

Answer: In 1987, the VA's Office of Inspector General issued an audit report, entitled "Audit of Estates Maintained for Incompetent Veterans". The I.G. recommended at that time that legislation be proposed which would authorize VA to limit the amount of funds held by fiduciaries of incompetent veterans which is subject to inheritance by distant relatives. Since that time, the Administration has been in the process of considering the most appropriate and equitable manner in which to accomplish the I.G.'s recommendation.

Question: 50(J)(ii). Was it proposed in VA's initial FY 1991 budget submission to OMB?

Answer: The proposal was not in VA's initial FY 1991 budget submission to OMB.

Question: 51. A nursing realignment, which is described as "the realignment of previously budgeted hospital to nursing bed conversions that have slipped from prior years," is mentioned on page 6-23 of the budget documents.

A. In what activities and at what facilities will the resulting decreases of $16,382,000 and 426 FTE in hospital resources in FY 1991 be applied?

B. In what specific VA nursing homes will the increased funding and FTE be used?

Answer: 51(A&B). The budgeted nursing realignment simply projects that there will be a shift in resources from hospital to nursing home activities. This occurs at individual VAMCs with scheduled nursing home activations that have been delayed until 1991. The resources that were temporarily utilized in the hospital activity will be shifted to the nursing activity in FY 1991. The facilities included in this shift of resources from the hospital activity to the nursing activity are San Juan, Philadelphia, Prescott, Chillicothe, Batavia, Canandaigua, Butler and Walla Walla.

Question: 52. The description of the Commission on Realignment (on page 6-23 of the budget documents) states, "The 1990 support requirements of $2,636,000 and 15 FTE will be funded from within the appropriation. Since only $439,000 and 3 FTE are required for 1991, reductions of $2,197,000 and 12 FTE are requested for 1991."

52(a). From where will the $2,636,000 and 15 FTE reduction come from in the 1990 budget?

Answer: The 1990 requirements of $2,636,000 and 15 FTE will be funded from the 1990 Congressional add-on.

Question: 52(b). What is the justification for these amounts coming from the Medical Care account rather than Medical Administration and Miscellaneous Operating Expenses (MAMOE)?

Answer: The VA is currently reviewing the appropriate funding source for this Commission.

Question: 53. On page 6-19 of the budget documents, decreases of $28,068,000 and 531 FTE are described as necessary to provide the resources for certain patient-care related program initiatives. In what specific activities funded in FY 1990 will these decreases be made?

Answer: Operational procedure development for "Resource redirection" has been assigned in VHS&RA to the Regional Financial Managers. The charge to this group is to recognize and include in the methodology the shift that is occurring from inpatient, intermediate care and probably long term psychiatry to outpatient programs and programs offering alternatives to inpatient care. Once these operational procedures have been developed and approved, it will be incumbent upon the line officials (i.e., Health Care Facility Directors and Regional Directors) to assure they are followed.

Question: 54. On page 6-19 of VA's budget books, it is stated that the FY 1991 resource redirection effort will increase by $15 million and 327 FTE the resources devoted to VA drug treatment programs. Is the $15 million increase in the drug treatment effort in addition to the FY 1990 $60-million Congressional add-on for drug and alcohol treatment programs, that is, is the $60 million now part of VA's baseline?

Answer: The 1990 $60 million Congressional add-on for drug and alcohol treatment programs is now part of the 1991 base and the $15 million increase in 1991 is a request over this base level.

This answer also responds to question number 71, which is identical to this question.

Question: 55. On page 6-19 of VA's budget books, it is stated that $487,000 and 7 FTE are requested to establish a compensated work therapy (CWT) program for substance abusers who have undergone detoxification and rehabilitation. "These veterans would pay rent in a domiciliary and work in CWT during the day." Please provide an opinion from the Genera Counsel on the legal authority under which VA would charge patients t stay in a domiciliary.

Answer: VA's proposal to have substance abusers live in therapeutic residences (i.e., medical facilities which we have analogize to domiciliaries), and participate in the compensated work therapy (CWT) program during the day, is unique. Requiring participants in the program to make a "rent"-like payment out of their earnings is also unique in the VA, and is an essential component of the patient's therapeutic rehabilitation. The General Counsel has not issued a formal opinion on the legality of this "payment' concept, and cannot, of course, prepare such an opinion in the short time before the budget hearing. The Administration's legislative proposal for this initiative will include language to establish such authority.

This answer also responds to question number 72, which is identical to this question.

Question: 56. According to VA information provided to the Committee, VACO is presently tracking all physician requests for prosthetic items (for patients) that are held more than five workdays.

56(a). It is somewhat unclear what is intended by "held more than five workdays". Specifically, from what point to what point (in the processing of prosthetics requests) are requests required, under VACO guidance, to be tracked?

Answer: The nature of prosthetic services and the complexities of the federal acquisition process makes it difficult to determine when an order becomes delayed in terms of point-to-point. Examples of delayed orders would be those delayed due to locating appropriate vendors, securing appropriate records, etc. Examples of orders cited by VAMCs which are not considered delayed are: pending prescription, pending fittings, changed medical conditions, awaiting discharge, discharge delayed, etc. Orders are tracked when the delay is caused by management or administrative action that delays prompt processing.

Question: 56(b). What specific guidance has been disseminated to VAMCs to ensure that prosthetic requests are consistently being tracked in this way?

Answer: The Associate Deputy Chief Medical Director established a uniform monthly reporting format requiring all Regions to report the name of the VAMC, number of orders held more than five workdays, the reasons for the delays and the corrective action taken. In addition, each Region has been requested to prepare a plan of corrective action to eliminate any delays which have been occurring. Prosthetic program officials have also been monitoring the reports submitted by the VAMCs and are working closely with the Regions in resolving any problems.

Question: 56(c). What, if any, feedback has VACO received from the field indicating that a different tracking policy may be in order?

Answer: The monthly reports from the field indicate some confusion as to what constitutes a delayed order. Many delayed orders being reported are actually those in the fabrication, fitting, training or delivery process. The Regional Directors, the Associate Deputy Chief Medical Director and Prosthetic program officials are refining guidance for preparing these reports.

Question: 56(d)(i). Is a different tracking policy being considered?

Answer: Yes, the Regional Directors, the Associate Deputy Chief Medical Director and Prosthetic program officials are working together to better define the parameters of a delayed order.

Question: 56(d)(ii). (If so) Please describe the changes being considered and when a decision on the policy is expected?

Answer: We would hope to better define a delayed order in more specific terms to improve the accuracy of the reports being submitted by the field. We hope this will be accomplished for the month of April but no later than May 1990.

Question: 57(A). In comparison to the VACO funding and FTE levels included in the President's FY 1990 budget request for the security service program, what funding and FTE levels are now planned for the program in FY 1990 and what is the source of the additional funding and FTE?

Answer: During FY 1990, the program will continue to receive those resources from the Medical Care and MAMOE appropriations previously set aside for this purpose. Some additional assistance is being provided by the Assistant Secretary for Human Resources and Administration.

Question: 57(B). In comparison to the VACO funding and FTE levels included in the President's FY 1990 budget request for the security service program, what additional FTE levels are needed in FY 1991 to provide adequate VACO oversight of VA security services in the field?

Answer: We are currently studying the Security and Law Enforcement program to determine the appropriate staffing levels for the oversight activity.

Question: 57(C). Does VA's FY 1991 budget for the General Operating Expenses (GOE) account include such additional funding and FTE?

57(D). If not, what are the amounts of the funding and FTE shortfalls?

Answer: Since the amounts are not known at this time, there are no specific funds earmarked for this purpose in the FY 1991 request.

Question: 58(A). What additional funding and FTE are needed in VACO in order to conduct VACO program evaluations of the security service at each VAMC every two years?

Answer: We are currently studying the program to determine the appropriate staffing levels for this activity.

Question: 58(B). Does VA's FY 1991 GOE budget include such additional funding and FTE?

58(C). If not, what are the amounts of the funding and FTE shortfalls?

Answer: Once again, these amounts are not known at this time.

Question: 59(A). How many additional FTE are needed to eliminate single-officer duty shifts at VAMCS?

Answer: We have initiated a survey to determine which VAMCs have only one police officer on duty during particular shifts. Once we have completed the survey we can determine how many additional FTE are needed to eliminate the single-officer duty shifts at all VAMCS.

Question: 59(B). Does VA's FY 1991 GOE budget include such additional funding and FTE?

Answer: VAMC police officer salaries are funded through the Medical Care appropriation.

Question: 59(C). If not, what are the amounts of the funding and FTE shortfalls?

Answer: Once we have completed the survey we will know what the appropriate resource levels are for this activity.

Question: 60(A). What specific plans does VA have to increase the length of police officer training at its police school in FY 1991?

Answer: We have recently increased the basic police officer training course from 64 to 80 hours. Our goal is to further increase the number of hours to 120 during FY 1991 and to 160 in subsequent years.

Question: 60(B). Does VA's budget for FY 1991 include the funding and FTE levels needed to implement such plans?

60(C). If so, in what amount (including FTE)?

60(D). If not, what will the FY 1991 costs and FTE requirements be for implementing such plans and out of which account will they be funded?

Answer: We are still working on estimating the additional staffing and travel and other operating costs required for this initiative. Funding will be provided from the appropriate account.

Question: 61(A). What plans does VA have to increase the protection afforded police officers at VAMCS, specifically as to vests, batons, and any other new items?

61(B). Does VA's budget for FY 1991 include the funding necessary to provide such additional protection?

61(C). If so, in what amount (including FTE)?

61(D). If not, what will the FY 1991 costs and FTE requirements be for providing such protection?

Answer: We do have plans to increase protection for VA Police Officers. However, we are currently in the process of determining what those protection needs may be. Only following that process will we be able to determine any additional needs for funding and FTE. Additional funding for police officer equipment needs would be provided in the Medical Care request.

Question: 62(A). What other plans does VA have to improve security at VAMCs?

62(B). Does VA's budget for FY 1991 include the funding and FTE levels necessary to make such improvements?

62(C). If so, in what amount (including FTE)?

62(D). If not, what will be the FY 1991 costs and FTE requirements be for making such improvements?

Answer: A four-year plan is being developed to address the need to improve the VA's security and law enforcement program and to identify the resources needed for this purpose. Ronald E. Ray, Assistant Secretary for Human Resources and Administration, and John H. Baffa, Deputy Assistant Secretary for Security and Law Enforcement, are available to meet with the Committee staff later this Spring and give them a detailed briefing and analysis of the plan. Resources for new initiatives envisioned in the four year plan have yet to be determined.

Question: 63(A). What plans does VA have to establish a new pay series for VAMC police officers?

63(B). Does VA's budget for FY 1991 include the funding necessary to make such improvements?

63(C). If so, in what amount?

63(D). If not, what will be the FY 1991 costs for establishing the new pay series?

Answer: There have been some preliminary discussions within the Department regarding a new job series for VA Police Officers. However, there is no plan for such at this time.

Question: 64. In the area of automated data processing (ADP) under the Medical Care account, it is noted on page 5-9 of VA's budget documents that the current FY 1990 estimates show increases in both funding and personnel over the original FY 1990 budget estimates reflecting "Congressional action as well as a greater level of support for the Agency's computerization program." For FY 1991, however, there are proposed decreases of $31.454 million and 105 FTEE. On page 5-10 it was stated, "The net change includes a decrease of 105 FTEE and $4,303,000 in personal services related to estimated time spent by application coordinators in support of DHCP, PAID and ISMS applications and a decrease for non-recurring equipment requirements for DHCP, PAID and ISMS of $34,894,000." Please provide a detailed explanation of the reductions in proposed FY 1991 funding and personnel for ADP under the Medical Care account.

Answer: The following chart details the decrease of 105 FTEE and $31.454 million in Medical ADP expenditures from FY 1990 to FY 1991.

	INCREASE/DECREASE ($ in thousands)					1991
	DHCP	OTHER	IHS	PAID	ISMS	CHARGE
FTEE	(105)	0	0	0	0	(105)
PAY & BEN.	(4,303)	123	1	0	0	(4,179)
MAINT.	3,287	0	0	441	0	3,728
EQUIPMENT	(27,196)	1,809	0	(4,544)	(3,154)	(33,085)
OTHER	2,405	(106)	(40)	(153)	(24)	2,082
TOTAL	(25,807)	1,826	(39)	(4,256)	(3,178)	(31,454)

The FY 1991 President's Budget for Medical Care ADP activities is decreased by $31.454 million and 105 FTEE from the FY 1990 level because we projected fewer staff hours would be spent in implementing and training in FY 1991 than are expected to be spent in FY 1990 when we are bringing up CORE+8 Applications.

During FY 1989 the Department was in the process of acquiring printers and video display terminals to support the DHCP CORE+8 applications as well as PAID and ISMS. Due to delays in the procurement cycle caused by prolonged periods of discussion with the vendors over technical and contractual issues, equipment testing and retesting, and turnover in VA contracting personnel, the contract awards will not be made until the 2nd and 3rd quarters of FY 1990. Therefore, we expect to spend a total of $36,066,000 on equipment for DHCP, PAID and ISMS in FY 1990 and only $1,172,000 in FY 1991 when there are no new initiatives.

The DHCP decrease of 105 FTEE and $4,303,000 in personal services is a combination of an increase of 54 FTEE and $2,096,000 in direct field support and a decrease of 159 FTEE and $6,399,000 in indirect support from application coordinators.

The $1,826,000 increase in OTHER is largely due to an increase in the equipment requirements associated with activations. The $39,000 decrease in IHS expenditures is mostly a decrease in travel as the RFP evaluation has been completed.

Question: 65. On Page 6-20 it is stated that in FY 1991 the various procurement initiatives noted on that page "are expected to result in savings of $11,936,000" and that the Integrated Supply Management System "will provide an estimated net savings of $13,064,000." Please provide a detailed description of how these estimated savings will be realized.

Answer: Programs such as FASTRAC, Standardization, and the Centralized Acquisition of Medical Equipment are realizing savings for our health care facilities. FASTRAC's overnight delivery of pharmaceutical items has delivered a cost avoidance of 55 percent over average wholesale prices to our customers in calendar year 1989. Additionally, by standardizing medical supplies at our health care facilities, we estimate 15 percent savings from prices currently paid. Also, VA and other government agencies are realizing savings from the centralized procurement of high-tech medical equipment. It is through these combined efforts that we project a FY 1991 savings of $11.9 million.

The Integrated Supply Management System (ISMS) developmental process has already allowed us to implement interim automation improvements to our existing system. The estimate of a $13 million savings is based on the annual expenditure of $1.3 billion for medical supplies. A one percent savings could be achieved by enhancing the VA supply system.

Question: 66. On page 6-21 it is stated that an "increased emphasis in the use of contract services is expected to result in savings of $2,180,000 and 136 FTE in 1991." Please provide a detailed description of how these estimated savings will be realized.

Answer: We will not know what savings will be derived until bid openings are held. It has been our experience to date (9 of 170 bid openings favored performance by a contractor or five percent of functions studied) that these cost comparison studies will result in the majority of these functions being retained in-house.

Savings projected for FY 1991 were estimated by applying an actual savings rate based on our actual experience in this area to the number of FTEE's scheduled to be studied for cost comparison in FY 1990.

Question: 67. on page 6-34 of the budget documents, it is stated that an additional $25,180,000 in Medical Care account funding is requested for FY 1991 "to support computerized systems equipment acquisitions."

67A. The description of this item further states, "This includes anticipated VAMC reprogramming of $17,944,000 for additional priority Automated Data Processing (ADP) systems and $2,236,000 for VAMC ADP applications that are not a part of DHCP." Please provide a description of the reprogramming, including details as to the activities that will be eliminated or reduced in order to fund these ADP items.

Answer: There are no eliminations or reductions involved as each years' priorities dictate the distribution of non-recurring resources. Within the VAMC's total equipment resources available, they identify the amount to be applied to their priority ADP requirements. (The reprogramming referred to in the budget documents in this instance is not the technical reprogramming between Medical Care account bases for which notice to committees is required.)

Question: 67(B)(i). It is also indicated on that page that the ADP equipment requirements associated with activations in FY 1991 is $5 million. Is that the full amount needed for such requirements?

Answer: The $5,000,000 for ADP included in the FY 1991 budget for activations is the estimated requirement for FY 1991. Activation requirements for a specific project may be requested over more than one year.

Question: 67(B)(ii). Please state the extent to which funding for them is provided in the budget request.

Answer: The $5,000,000 in ADP equipment identified on page 6-34 is a part of the total equipment requirements included in the facility activation request.

Question: 68. On page 6-22 of the budget documents, in the listing of total space changes for real estate rentals, a new outpatient clinic for Bakersfield,, California, was shown with a cost of $206,000 and new satellite outpatient clinics in California (with dollars associated) were listed as follows: San Francisco ($39,000), San Jose ($122,000), San Diego ($3,000,000), and Palo Alto (minus $57,000). Please describe what each of these figures represents, the satellite locations anticipated, the workload and services involved, and the acquisition and activation schedules, and explain why Palo Alto was shown with a negative amount.

Answer: In the cases cited, the cost figures shown on page 6-22 of the budget documents represent changes to amounts already in the medical care base. The Bakersfield outpatient clinic is a new satellite of VAMC Sepulveda, CA. The projected workload for the clinic is 25,500 annual visits. Services provided by the clinic are ambulatory care; general medical clinics; audiology; clinical cardiology laboratory; dental; ear, nose and throat; eye/optometry; genito-urinary laboratory; orthopedic/podiatry; outpatient psychiatry; pharmacy; prosthetics; radiology and rehabilitation medicine. Lease award is now anticipated in November 1990, with activation anticipated in February 1992.

The San Jose mental health clinic is a satellite of VAMC Palo Alto, CA. The clinic is an existing facility undergoing relocation/expansion. The workload for this clinic is included in the total workload for VAMC Palo Alto (Menlo Park), CA. Psychiatric rehabilitation and day treatment are the services offered at the facility. The current anticipated award as opposed to the original planned award for the lease is July 1990, with activation projected for October 1991. One hundred twenty-two thousand dollars ($122,000) more in rent will be required in FY 1991.

Please note that the relocation/expansion listed for San Francisco is that of the Regional Director's Office and that those listed for San Diego and Palo Alto are for research facilities. Also, the budget documents show the funding increase for San Diego at $300,000 not $3 million, and Palo Alto at $433,000 not minus $57,000.

Question: 69: With regard to increased medical and support services associated with new activation, page 6-38 of the budget documents shows FY 1991 FTE and obligations for new outpatient clinics. The California facilities listed Bakersfield, showing 9 FTE and $439,000, and San Jose, showing 16 FTE and $681,000.

69(a). Please describe what the obligation figures represent.

Answer: The FY 1991 budget request for San Jose includes $592,000 for personal services, $75,000 for other operating expenses and $14,000 for employee relocation; for Bakersfield $333,000 for personal services, $97,000 for other expenses and $9,000 for employee relocation. These resources will provide for start-up activities (employee hiring, training, purchasing supplies and equipment, etc.) needed in preparation for the activation of the clinics in late 1991. Additional resources will be requested in the 1992 budget for full operations.

Question: 69(b). Please provide a description of your plans for both California facilities, including workload, services, and acquisition and activation schedules.

Answer: When fully operational San Jose and Bakersfield will provide for 74,200 and 25,500 outpatient services, respectively. Estimated lease award dates are 7/90 and 7/90, respectively; activation dates are 10/91 and 9/91. Services are described in the response to question 68.

Question: 70. On page 6-40 of the budget documents, there is a listing of community-based clinics that have been approved through MEDIPP for activation in FY 1990 or 1991 and that "are subject to local funding availability." The California locations for community-based clinics are Monterey/Salinas, Orange County, and Yountville.

70A. Is it anticipated that local funding will be available for each of those clinics?

Answer: No.

Question: 70B. Please provide a description of your plans for these community-based clinics, including workload, services, and acquisition and activation schedules.

Answer: Plans for the Monterey/Salinas initiative are not complete; however, we have agreed to provide some medical service, including, at a minimum, prehospital assessments health screening, counseling and post-hospital follow-up care.

The Orange County initiative includes a psychiatric day treatment program and a halfway house for substance abusers. The day treatment program is a collaborative effort between a VA hospital, city agencies, state agencies and private organizations. The program is targeted specifically for chronic patients residing in group homes, board and care facilities or the homeless. The day treatment program will accommodate about 7,000 patient visits and is scheduled for implementation in FY 1990.

The proposed psychiatric halfway house program is needed for those veterans with a history of substance abuse along with a major psychiatric diagnosis who are either among the homeless or living very marginally. Estimated workload is 4,015 contract patient days. Implementation is scheduled for FY 1990.

For a number of years, VAMC San Francisco has provided several outpatient clinics at the California State Veterans Home in Yountville for veteran home residents. These include weekly Dermatology and Optometry clinics and a bi-weekly Vascular Surgery clinic which total approximately 1,800 visits per year. The MEDIPP initiative originally envisioned by VAMC San Francisco was to expand this program to provide a regular General Internal Medicine clinic as well as additional scheduled medical and surgical subspecialty clinics to serve not only the State Home veteran population, but also those veterans residing in the North Bay catchment area (primarily Napa and Sonoma counties). This program expansion is still under review at the medical center level.

Question: 71. See question 54.

Question: 72. See question 55.

Question: 73. In connection with the February 1 hearing on the nomination of D'Wayne Gray to be Chief Benefits Director, Mr. Gray stated that 233 of the 226-FTE reduction in the FY 1991 budget request for VBA "was a fair trade-off for the increased productivity the ADP modernization should provide" and "are associated with [VBA's] detailed cost-benefit analysis". He also stated that "the remainder of the modernization program is directed more towards improving the quality and timeliness of the VBA's service to the veteran, rather than the automation of routine manual operations of the sort that can result in direct FTE savings".

73(A). At what point in VBA's ADP modernization program will that change occur?

Answer: Each initiative is justified on the basis that it will provide a beneficial result. Measurement of those results is shifting from FTEE savings to productivity (timeliness and quality) improvement as ADP modernization implementation occurs.

Question: 73(B). How many FTE do you expect to be saved during the "remainder" of the modernization effort?

Answer: Between FY 1992 and FY 1995, we anticipate saving an additional 436 FTE. These savings are attributable to implementation of the remaining short-term initiatives. However, the concept of reducing FTE levels due to automation "savings" instead of redirecting the FTE to other needed program areas is being reevaluated for the 1992 budget.

Question: 74. During the February 1, 1990, hearing on the nomination of D'Wayne Gray to be Chief Benefits Director, I asked him to describe the status of the VA Loan Production System (LPS). I have attached a copy of his response, which indicates that phase I of LPS will be fully installed by March 1991, but that phase II has no schedule for development or installation because the FY 1991 budget provides no funds for the project.

74(A). Please describe the minimum time necessary to complete each major step in phase II, through final installation, if full funding were available.

Answer: Regarding the reference to phase I installation, only the Code Sheet Elimination component would be installed by March 1991.

Ideally, the three subsystems of LPS II - LGY Index, Loan Claims System (LCS) Redesign and Portfolio Loan System (PLS) Replacement - would be implemented concurrently, with some overlap between projects. Assuming funding were made available, individual schedules would be as follows:

LGY Index - Formulation of functional specifications could begin in the fourth quarter 1990, with final implementation in approximately 14 months (first quarter 1992).

LCS Redesign - Formulation of functional specifications could begin in May 1990 followed by system prototyping at several stations within approximately 15 months. With full contractor support, nationwide implementation could be completed by fourth quarter 1993.

PLS Replacement - Formulation of functional specifications could begin in the fourth quarter 1990. Procurement of an off-the-shelf package and subsequent customization and installation could be completed by the third quarter 1992.

Question: 74(B). Please describe the funding requirements, and the date by which such funding would be required, for each step of phase II through final installation under the timeframe indicated in your response to part A of this question.

Answer: The funding required for each component of LPS, phase II is summarized below. (The schedules presented in response to part A of this question are based on the assumption that funds are available at the beginning of the fiscal years for which they are requested.)

LGY Index - Our estimate for FY 1991 includes $225,000 for contractor support and $1,440,000 for equipment. This equipment (Direct Access Storage Devices and communications processors) would support both the LGY Index and the PLS Replacement.

LCS Redesign - We estimate a total of $675,000 for contractor support in FY 1991 and $1 million in FY 1992. Equipment costs are estimated at $200,000 in 1991 and $8 million in 1992.

PLS Replacement - Our estimate for purchase of software in FY 1991 is $660,000. Equipment costs are included in those specified for LGY Index.

Question: 75(A). Why is the Veterans' Advisory Committee on Environmental Hazards funded from the MAMOE account, rather than from the GOE account, when its functions are related basically to entitlement to disability compensation and DIC -- not to health-care eligibility?

Answer: The Committee functions primarily as a scientific advisor to the Secretary as it reviews the scientific literature relating to the health effects of exposure to herbicides containing dioxin or to ionizing radiation. Consequently, it was determined that it would be more appropriate to fund the Committee from the MAMOE appropriation.

Question: 75(B). Does not the Department have considerable discretion as to the account to be charged for such an advisory committee's function, and would the GOE account be not only more fitting functionally but appropriate in terms of the extreme MAMOE shortfall, which is preventing this Advisory Committee from carrying out its responsibilities effectively, especially in terms of meeting to evaluate the new BEIR V report?

Answer: While the Department does have some discretion as to the account to be charged to fund the Committee's activities, funding is not affecting the ability of the Committee to carry out its responsibilities. We believe that the Committee has been meeting the needs of the Department in an effective manner. A variety of factors influence the frequency of Committee meetings. One important factor is the ability of the Committee's members to meet on a more frequent basis. As a result of the Nehmer decision last May, the Committee has been required to focus its attention on studies relating to Agent Orange, a considerable task in itself. The Veterans Benefits Administration has requested the Committee to review BEIR V. A decision as to when the Committee will address that request has not yet been made.

Question: 76. On page 23-148 of the budget document, it is stated that an initiative to reduce BVA response time was begun in FY 1990 and is planned to continue through FY 1991. Thus, despite an increase of only 8 FTE over the FY 1989 staffing level, the number of appeals decided is planned to increased by 6,477 from FY 1989 to FY 1991.

Question: 76(A). Please explain how this 17-percent increase in production is planned to be achieved with only a 2-percent increase in staffing.

Answer: At the core of this BVA response time reduction initiative is productivity improvement. The principal means through which we expect the BVA to achieve this productivity improvement include streamlining of BVA process requirements in both its Professional and Administrative Services, minimization of professional staffing overhead requirements, increased use of office automation tools and more efficient decision review processes. Implementation of several of these measures has already begun, and we expect to be able to initially assess their impact on the BVA's overall productivity level sometime later this year.

Question: 76(B). Please describe each of the actions being taken to improve productivity, provide an estimate of the effect each is expected to have on productivity, and describe the potential impact of each action on the quality of BVA decisions (including the effect of reducing decision-review activities).

Answer: The actions that are being taken or are planned to be taken to improve BVA productivity each represent some departure from past BVA practices. This plan of action was developed as a whole after considering the pressing issue of a rising BVA response time. Since the various actions comprising this overall plan do represent new or substantially revised BVA process changes, we have not yet attempted to quantify the expected productivity gains of the individual component parts of this plan, and any component breakdown provided now would be sheerly speculative. The approach that we have taken towards this initiative is to establish the overall organizational response time goal and then to collectively look at the productivity improvement measures that we believe will be necessary and appropriate to reach this goal. Descriptions of some of the more significant productivity improvement measures that have either been implemented or are under development by the BVA are as follows:

Minimize Acting Board Member Designations Through the Use of Two Board Member Decisions. The BVA's practice has always been to require three reviews of all cases and three Board Member signatures on all decisions. Where Board Member vacancies existed or when a Board Member was absent as a result of travel, illness or leave, the authority of 38 U.S.C. (4002(a)(2)(A) was utilized to designate senior staff attorneys to serve as Acting Board Members. This solved the need for the third Board Member signature on each decision, but resulted in removing senior attorneys from decision production roles. This practice has been reconsidered in view of the Board's production needs, and decisions are now being released with only two Board Member signatures in the event of a Board Member vacancy or temporary absence. This procedure is permissible under the statutory authority noted above and will virtually eliminate the Board's need to designate senior attorneys as Acting Board Members. As a result, the amount of staff attorney time available for production will be substantially increased. Increased utilization of this authority has enabled the BVA to temporarily reconfigure its primary professional staff from 21 to 22 Board Sections, thus providing enhanced production capabilities.

Reduction of Other Nonproductive Attorney Time. The Board's policies and practices relative to utilizing staff attorneys for functions other than BVA decision production have been reviewed and strengthened in general. Board Sections' freedom to utilize staff attorneys for any purpose other than for decision production is now far more limited than it was previously. Other areas where we will be limiting the incidence of nonproductive attorney time include: reducing the amount of staff attorney time spent on executive development and other training that is not essential to accomplishing the BVA's basic mission; limiting the granting of administrative leave for attorneys to events needed to satisfy legal requirements for bar membership; and minimizing the incidence of staff attorney performance of temporary duty travel. The ultimate goal of these changes in BVA staff utilization practices is to concentrate the use of personnel resources on production as opposed to overhead activities.

Abbreviated Decision Formats. Abbreviated decision formats are being developed for use in the most routine cases. We do not contemplate that our potential application of such decision formats would be widespread (probably no more than 10% of our appellate decisions). When applicable, however, reduced discussion and recitation of evidence will streamline the decision development process and reduce associated time requirements.

Automation Tools.

Bar Coding. The BVA is incorporating bar coding technology into its case tracking and locator system during this fiscal year. We are extremely optimistic that this initiative will produce measurable productivity gains in several areas throughout the BVA. In addition to the obvious data entry labor savings involved in supporting a case tracking system, we anticipate that the accuracy level of the tracking system data will be greatly improved, thus reducing case searching times and speeding up many Administrative Service functions.

Automated Decision Development Tools. The BVA has developed a series of standardized, centrally maintained files of standard language that is commonly utilized in its decisions. Language from these files may be invoked and incorporated into documents prepared on the Board's centralized office automation and word processing system. Directories of these centralized files are available to BVA attorneys, and the standardized material may be invoked either by an attorney working at a terminal or by a typist transcribing dictated material. The system currently contains over 1,750 reference files pertaining to standardized diagnostic codes and 192 reference files pertaining to laws and regulations.

Decision Quality Impact. We feel that none of the productivity measures described above will adversely affect any of the truly substantive aspects of quality relative to BVA decisions. We regard as indispensable any qualitative aspect of the VA appellate program that will have a bearing on the ultimate results of BVA final decisions, i.e., whether a case is allowed or denied. We do not feel that there is room for compromise relative to quality at this level nor is there any room for compromise relative to the due process rights of VA appellants. We feel that none of the productivity improvement measures discussed above will have a negative impact on decision quality in this sense.

Question: 77(A). What amount is included in the Medical Care account for FY 1991 for prosthetics?

Answer: The budget includes $142,440,000 for prosthetics and repairs to prosthetic appliances.

Question: 77(B). What percentage change does that represent from total prosthetics funding for FY 1990?

Answer: 5.5% increase

Question: 77(C). What factors have influenced that percentage change in prosthetics funding?

Answer: Trend analysis based on cost and usage.

Question: 78(A). Has VA assessed the size and needs of the eligible veterans population of prosthetics users so that a budget forecasting model could be developed?

Answer: No, however, information is available on those veterans with continuing eligibility who use prosthetic devices.

Question: 78(B). If so, what are the size of the population and the projected needs?

Answer: As of September 30, 1989, our active treatment rolls included the following information:

Amputees Lower Extremity	42,717
Amputees Upper Extremity	7,516
Blind	15,932
Brace Cases	78,625
Deaf	162,119
Foot Disabilities	90,562
Paraplegic	13,350
Quadriplegic	7,630
Hemodialysis	1,074
Other Disabilities	533,667
Total	953,192

The above information has not been used to develop a budget forecasting model and does not include data concerning treatment of most nonservice-connected veterans by VA medical centers.

Question: 78(C). If not, on what bases has the prosthetic budget been developed?

Answer: Trend analysis of actual cost and usage submitted by each VA medical center.

Question: 79(A). What specific guidance is provided to the individual VA medical centers to assist them in estimating their prosthetic budgets?

Answer: Data on workload and budget trends (covering eight year periods) have been distributed to all VAMCs for the last three years. Training has also been provided to Chiefs of Prosthetic Service on budget trend analysis at the last two national conferences in 1986 and 1988. This type of training is also part of the prosthetic representative management training program. Specific guidance is also included in VHS&RA Manual M-2, Part IX, paragraph 3.01d.

Question: 79(B). If no guidance is provided, why is it not?

Answer: Not applicable.

Question: 80(A). In which of the last 5 fiscal years has a prosthetic funding shortfall occurred?

Answer: Given that annual appropriations have met or exceeded the Administration's request, there has been no funding shortfall for prosthetics in the last 5 fiscal years.

Question: 80(B). What is the likelihood that a funding shortfall will occur in FY 1990 or FY 1991?

Answer: Given the additional funding provided for prosthetic services for FY 1990 and the budget request for 1991, no shortfall should occur.

Question: 80(C). What specific changes has VA made to its prosthetics budget forecasting to preclude funding shortfalls occurring in FYs 1990 and 1991?

Answer: VA has provided guidance to the field establishing a priority for procuring prosthetic items. This should preclude prosthetic backlogs in FY 1990 and 1991.

Question: 80(D). What is the VAs projected backlog of prosthetic orders at the end of each of FYs 1990 and 1991?

Answer: The VA is committed to managing the provision of prosthetic services, so that backlogs of orders are held to a minimum. At this time, we have no projections of an end of year backlog level.

Question: 81(A). It is my understanding that there are prosthetic representatives at only 84 of the 172 VAMCs. What criteria are used to determine whether a particular VAMC needs a prosthetic representative?

Answer: VA medical centers determine the need for a prosthetic representative based on workload as defined by patients served and other complexity factors relating to specialized medical care programs, divided/multiple facilities and geographical responsibility. Generally, facilities with annual workloads which exceed 2,500 prosthetic patients served could justify full services managed by a qualified chief. Facilities with prosthetic workloads in excess of 1,000 patients served could justify a full-time prosthetic representative.

Question: 81(B). Please identify the VAMCs which lack a prosthetic representative but meet the criteria for the employment of one?

Answer: Facilities treating over 2,500 patients without a full service are:

VAMC Columbia, MO
VAMC Boise, ID
VAMC North Chicago, IL
VAMC Hampton, VA
VAMC Fresno, CA
VAMC Asheville, NC
VAMC Durham, NC
VAMC West Haven,, CT
VAMC Manchester, NH
VAMC Oakland Park, FL
VAMC Topeka, KS
VAMC Mountain Home, TN
VAMC Columbus, OH
VAMC Dayton, OH
VAMC Iowa City, IA
VAMC Toledo, OH
VAMC Lebanon, PA
VAMC Chicago (Lakeside), IL
VAMC Chillicothe, OH
VAMC Riviera Beach, FL

Facilities without Prosthetic Services that treat over 1,000 patients are:

VAMC Madison, WI
VAMC Salem, VA
VAMC White River Jct., VT
VAMC Lincoln, NE
VAMC Lexington, KY
VAMC Leavenworth, KS
VAMC Castle Point, NY
VAMC Clarksburg, WV
VAMC Martinsburg, WV
VAMC Jacksonville, FL
VAMC Alexandria, LA
VAMC Waco, TX
VAMC Charleston, SC
VAMC Hot Springs, SD
VAMC St. Cloud, MN
VAMC Prescott, AZ
VAMC Northampton, MA
VAMC Lake City, FL
VAMC Bath, NY
VAMC Pensacola, FL
VAMC Anchorage, AK
VAMC Daytona Beach, FL
VAMC Fayetteville, NC
VAMC Saginaw, MI
VAMC Fayetteville, AR
VAMC White City, OR
VAMC Dublin, GA

Question: 81(C). What would be the cost of employing those additional representatives?

Answer: The estimated cost in FY 1991 would be $1.7 million. The FY 1991 VA request for the Medical Care account is $12.3 billion, almost $1 billion over the FY 1990 level. Within this total request, prosthetics activities may be funded if they are consistent with the Secretary's priorities for veterans' health care and are determined to be cost-effective.

Question: 81(D). To what extent has that added cost been reflected in the *FY 1991 Medical Care account budget?

Answer: Funding for prosthetic representatives is not specifically identified in the FY 1991 budget.

Question: 82(A). What specific plans does VA have to increase the number of prosthetic programs evaluations conducted on-site by VACO staff in FY 1991?

Answer: Operating plans for MAMOE account for FY 1991 have not been developed at this point in time, therefore, we do not know what level of activity will be funded in FY 1991.

Question: 82(B). Does the FY 1991 budget reflect those plans and, if so, at what cost (in funding and FTE)?

Answer: The FY 1991 budget does not specifically identify plans for such on-site visits.

Question: 82(C). If not, what will be the costs (in funding and FTE) of implementing plans?

Answer: Operating plans for the MAMOE account for FY 1991 have not been developed at this point. Therefore, we do not know the costs of implementing evaluation plans.

Question: 83. The March 1988 report prepared by Angela Franklin Ford and Lewis D. Houck, entitled "Analysis of VA Orthotic Laboratories", considered that VA-produced orthotic appliances cost substantially less than commercially-procured appliances and, on that basis, recommended that VA explore the possibility of expanding VA orthotic services.

Question: 83(A). What specifically has VA done to explore that possibility? (If a study was carried out, please provide a copy of the report of the study.)

Answer: Guidelines for the establishment of orthotic laboratories were included in the MEDIPP planning directives, G-1, M-9, Part I, Chapter 20. Policy for the establishment and operation of a VA Orthotic Laboratory are also included in VHS&RA Manual, M-2, Part IX, Chapter 2, paragraph 2.07b.

Question: 83(B). What criteria are used to determine that a VAMC needs an orthotic laboratory.

Answer: Space requirements, equipment costs, supplies and recurring FTE salary are determined and compared to the cost of procurement of those items which could be fabricated by the VA laboratory if it were established, i.e., the cost of temporary limbs, braces, corsets/belts, elastic base, etc. Where cost effective, orthotic laboratories would be justified.

Question: 83(C). VA currently has an orthotics laboratory at 55 VAMCs. At how many additional VAMCs is an orthotics laboratory needed.

Answer: The following VAMCs have met the planning criteria of the MEDIPP process or the cost containment initiative in the Great Lakes Region:

VAMC Newington, CT
VAMC Augusta, GA
VAMC El Paso, TX
VAMC Indianapolis, IN
VAMC Baltimore, MD
VAMC Dayton, OH
VAMC Phoenix, AR
VAMC West Palm Beach, FL

Question: 83(D). What would be the cost of establishing those needed laboratories in FY 1991?

Answer: The estimated cost in FY 1991 would be $680,000. The FY 1991 VA request for the medical care account is $12.3 billion, almost $1 billion over the FY 1990 level. Within this total request, those laboratories may be funded if they are consistent with the Secretary's priorities for veterans' health care and are determined to be cost-effective.

Question: 83(E). To what extent is the cost of those additional laboratories reflected in the FY 1991 budget?

Answer: None specifically. Implementation of MEDIPP initiated projects is determined based on the prioritized needs of VHS&RA.

Question: 83(F). The Washington VAMC does not have an orthotics laboratory and, therefore, had to buy commercially 311 braces in FY 1988. That number of braces is larger than the number of braces produced by 27 of the 55 existing VAMC orthotics laboratories in that fiscal year. Given those data, why does the Washington VAMC not have an orthotics laboratory?

Answer: The number of braces is not a reliable indicator of the need to establish orthotic laboratory since costs vary significantly depending on the type of brace being ordered. In reviewing the available data, FY 1988 was an unusually high cost year when $85,625 was expended for commercial purchases for braces. In FY 1987, $60,583 was expended and in FY 1989, $45,355. The amounts expended in the more normal years, i.e., 1987 and 1989, do not clearly indicate that establishment of an orthotics laboratory would be cost-effective.

Question: 84. The September 1985 report prepared by Marshall Amesquita, Joanne M. Lynch, and Angela Franklin Lord, entitled "Analysis of VA Restoration Clinics", recommended that VA establish additional eye restoration clinics in the southeastern and southwestern areas of the country because these areas have high unmet needs and are using expensive commercial facilities. Why has that recommendation not been implemented?

Answer: The recommendation has not been implemented because the underlying projects are not of high enough priority in relation to the other programs in VA Medical Care.

Question: 84(B). What would be the FY 1991 cost of establishing the additional restoration clinics that VA believes would be cost-effective but for which funding is not included in the FY 1991 budget?

Answer: The estimated cost in FY 1991 would be $102,000. The FY 1991 VA request for the Medical Care account is $12.2 billion, almost $1 billion over the FY 1990 level. Within this total request, these activities may be funded if they are consistent with the Secretary's priorities for veterans' health care and are determined to be cost-effective.

Question: 84(C). The report states there is a correlation between loss of eyes and age-related diseases. In light of the growing number of older veterans, what specific plans does VA have to increase the number of eye restoration clinics in FY 1991?

Answer: Available data do not support this correlation nor is VA being overwhelmed with requests for artificial eyes. The number of patients being provided artificial eyes has not substantially increased or decreased during the last four fiscal years. Given that 65% of the artificial eyes provided are for war related trauma, decreases in patient load are expected as the World War II service-connected veteran population decreases.

Question: 85(A). With regard to the planned transfer of Loan Guaranty operations now at the Togus, Hartford, and Boston VAROs to a consolidated New England Loan Guaranty Division at the Manchester, New Hampshire, VARO what comparable positions do you hope to offer the technical employees declining to transfer, particularly the Loan Guaranty Officers?

Answer: Officials of VARO Boston, VARO Hartford and VAMROC Togus will identify the number of Loan Guaranty technical staff rejecting the directed reassignments to VARO Manchester. Based on staffing and workload criteria, local officials will determine the number of employees who will receive assignments to technical positions in the remaining Divisions at each station, such as Claims Examiner, Veterans Benefits Counselor and Vocational Rehabilitation Specialist. Management officials will attempt to accommodate the desires of employees, but the actual number of employees assigned to the identified divisions will be based on the operational requirements and needs of each facility. There is only one Loan Guaranty Officer (LGO) position, outside of Manchester, which is currently filled. This position is in Boston. The Boston LGO will be offered a management position at the combined Manchester Loan Guaranty division and/or other available management positions in Boston or elsewhere in VBA.

Question: 85(B). If employees whose positions are eliminated but who decline to transfer will be absorbed as normal attrition creates vacancies, will there be gaps in needed skills or expertise at Togus, Boston and Hartford until the assimilation is complete?

Answer: No. These employees will be assuming positions in the field station where they will have basic familiarity with the program and procedures . They will bring with them a much higher level of experience than that which would come from "new hires" the office would otherwise employ.

Question: 85(C). The combined Loan Guaranty workforce of Togus, Hartford, Boston, and Manchester is 31 FTE. The proposed staffing for the consolidated Loan Guaranty Division is 22 FTE. What are the nine positions being eliminated?

Answer: VA has recently re-evaluated the FTE needs based on the workloads accomplished for FY 1989 and the workloads projected for FY 1990. As a result the proposed staffing has been increased to 25.

The positions being eliminated are: 3 Loan Guaranty Officers, 2 secretaries, 1 construction analyst, and 2 loan specialists which is a reduction of 8 positions. However, an Assistant Loan Guaranty Officer and a Specially Adapted Housing Agent are being added resulting in a net reduction of 6.

Question: 85(D). Will the reduction of technical personnel leave sufficient staffing to cover adequately the full six-State region, especially in areas, such as construction and specially-adapted housing, where there will be only one employee with that primary responsibility?

Answer: There will be one construction analyst and one specially adapted housing agent whose primary responsibility will be processing SAH applications. In the four existing offices, specially adapted housing actions are processed by employees who are assigned other duties. Centralized authority to approve grants will be given to the consolidated office. This should expedite service to disabled veterans seeking specially adapted housing in the New England area.

Question: 85(E). According to the detailed plan and justification for the transfer of Loan Guaranty functions from Togus to Manchester which you transmitted to me on January 22, 1990, it is anticipated that any delinquent borrower visiting a VA office with no Loan Guaranty Division will be able to receive personal service and Loan Guaranty program information through a Veterans Benefits Counselor (VBC) in the Veterans Services Division at each location. Please describe your plans for training the VBCs.

Answer: It has been a long-standing policy that counselors in VSD answer general inquiries on loan guaranty matters and issue original Certificates of Eligibility. VSD personnel cannot easily answer questions regarding specific case processing as responses require a review of the loan folder. However, at most stations case specific or detailed technical questions presented to VSD are handled through the veterans assistance inquiry (VAI) system or through direct referral to the Loan Guaranty Division.

VBA Circular 20-89-15 requires that employees issuing Certificates of Eligibility be given training at least once a year. Veterans Services Divisions also require that all technical personnel receive at least 12 hours of official training per quarter. Loan Guaranty will keep all the offices in New England informed of program changes and will provide training as needed.

Question: 85(F(i). Will VBCs in Manchester also provide Loan Guaranty personal service and program information?

Answer: Yes.

Question: 85(F)(ii). Do you think that other ROs should provide similar training and use VBC's in this manner?

Answer: The majority of ROs do. Because workloads and staffing dictate the need for support from outside functional lines, there are variances between VBD support to Loan Guaranty Divisions in ROs. Workload in the Loan Guaranty Program is subject to fluctuations in interest rates and other economic variables. When there is an increase in workload in any program area, station management determines the staffing balance/workload emphasis that will best serve the overall veteran population.

Question: 85(F)(iii). If not, why not?

Answer: Not applicable.

Question: 85(G). How much funding devoted to Loan Guaranty travel within the six-State region will be protected from reduction in the event of sequestration, and how does that amount compare with the current travel funds budgeted in total for the same area?

Answer: To ensure the success of the consolidation, preserving Manchester's Loan Guaranty travel funds will be one of our first priorities. The actual amount of the funds protected would depend on the severity of the sequestration. However, the impact on the consolidated operation would not be as severe as it would be the station remained independent.

SENATOR ALAN CRANSTON

Question: 1. What is the current length of time that patients must wait for screening and for treatment at each of the 16 specialized inpatient PTSD units (SIPUs)?

Answer: The following is a summary of waiting list data for the 16 SIPUs as of December 1989:

LOCATION	WAITING PERIOD
1. Palo Alto/Menlo Park:	2 months, treatment
2. Tomah:	3 weeks, treatment
3. Bay Pines:	no waiting list
4. Coatesville:	5 days, screen; 4 months, inpatient assessment; 5 months, treatment
5. Northampton:	6 months, screen; 6 months, treatment
6. Topeka:	4 months, treatment
7. North Chicago:	4-6 months, screen; 1 week, treatment
8. Phoenix:	5 months, screen; 1-3 weeks, treatment
9. Augusta:	5-10 weeks, screen; 2 months, treatment
10. Tacoma (American Lake):	6-8 months, screen; 10-12 months, treatment
11. Montrose:	4 weeks, screen; 5 weeks, treatment
12. Lyons:	6 months, screen; no wait, treatment
13. Buffalo:	no wait, screen; 2 months, treatment
14. Togus:	4 months, evaluation; 4 months, treatment
15. Little Rock:	treatment only: 1 month, if S.C. for PTSD; 4 months if S.C. for other than PTSD; 8 months for N.S.C.
16. Cleveland/Brecksville:	8 weeks, assessment; 6 weeks, treatment

The average length of time veterans must wait for screening is 10 weeks with a range of 0-32 weeks. Three SIPUs have no screening waiting list; one, (Tacoma) has a 32-week wait, and three have a 24-week wait.

The average length of time a veteran must wait for treatment is 11 weeks with a range of 0-52 weeks. Only Tacoma has a 40-52 week waiting list; two SIPUs have no treatment waiting list. The 1988 survey revealed an average length of time for the SIPU treatment waiting list to be 7.5 weeks with a 1-24 week range.

Question: 2(A). What percentage of patients screened and patients treated at each of the SIPUs are from outside those facilities' catchment areas?

Answer: Data is currently being collected on the percentage of patients from each SIPU that are from their Primary Service Area (PSA) and how many are from outside their PSA. Initial impressions are that many, if not all SIPUs take referrals from outside their own PSA and, in some cases, from areas covered by other SIPUs.

Question: 2(B). Please explain the method through which SIPUs are reimbursed and describe whether the reimbursement method differs when SIPUs treat patients from outside their catchment areas.

Answer: The funding for SIPUs was begun with a limited number of FTE from the national level (1 to 4 each in 1988). The remainder of the funding was provided locally. The reimbursement method doesn't differ for those patients outside the catchment area.

Question: 2(C). Are discretionary funds under the control of the Regional Directors used to assist SIPUs within their respective regions when the SIPUs treat patients who are from within their regions but outside their designated catchment areas?

Answer: The fact that SIPUs treat patients outside their catchment areas is not significant in the context of funding from the Regional Directors.

Once activities become established at the hospital level, funding is available to them through the RAM mechanism based on workload. If shortfalls exist, supplemental assistance from the Regional Director would be considered.

Question: 2(D). In your view, should an SIPU be supported by discretionary regional funds (such as is the case with a Spinal Cord Injury Unit) in situations where it is treating significant numbers of veterans who are from within the SIPUs respective region but outside its catchment area?

Answer: When establishing an SIPU (or any other specialized unit with treatment responsibilities that extend beyond the parent facility's PSA), the expectation is that patients from outside the immediate facility PSA will be treated and the unit is accordingly funded for the projected workload, given the availability of resources. If workloads increase, and/or funding shortfalls occur, the supervising Regional Director would be expected to assess the situation and determine if supplemental funding is necessary to accomplish the planned workload.

Question: 2(E). In the Third Annual Report of the Chief Medical Director's Special Committee on PTSD, Table 1.5 provides a breakdown by region and station of Vietnam era veterans who were discharged with PTSD and with any primary psychiatric diagnosis in FYs 1984 and 1985.

(i) Has there been any similar study conducted by VA since 1987 that would allow a more current comparison of the numbers of veterans with PTSD who are being seen within regions and by individual stations?

Answer: The Third Annual Report on PTSD, Table 1.5, compared number of veterans discharged with PTSD to number discharged with any primary psychiatric diagnosis in FY 1984 and FY 1985. Similar surveys of the FY 1986 and FY 1987 Patient Treatment Files (PTF) were carried out by Mental Health & Behavioral Sciences Service. For FY 1988, the survey was limited to a comparison of discharges of patients in VAMCs with SIPUs to total PTSD discharges. Data for FY 1989 have recently been collected for PTSD discharges for all VAMCs, and these data are currently under review.

Question: 2(E)(ii). What criteria are used in determining the locations of SIPUs?

Answer: The SIPUs that have been established since FY 1984 have been developed through the Medical District Initiated Planning Process (MEDIPP). Among the criteria for program designation are: expressed interest and support by the VA medical center; a proposed plan of treatment that is acceptable to Regional Planners (with clinical input) and demonstration of patient need (i.e., numbers of patients) validated through the VACO Office of Strategic Planning. There is VACO Mental Health and Behavioral Sciences Service input and approval for these plans.

Question: 2(E)(iii). Do the locations of SIPUs generally correspond to the areas that have been identified as having the largest numbers of veterans with PTSD?

Answer: Numbers of patients with PTSD in the VAMC's primary service area is certainly one consideration in determining the site of a new PTSD program. Local clinical and VAMC leadership support, and clinical strength are also important elements in planning for a successful program. In siting PTSD clinical teams in FY 1989, for example, emphasis was placed on establishing services in the Southeastern, Southwestern, and Western Regions, where there are significant numbers of veterans and services were needed.

Question: 2(E)(iv). As to the four new SIPUs VA plans to activate in FY 1990, please describe where they will be located and when they will be activated and explain whether these locations have been identified by VA as containing significant numbers of veterans with PTSD.

Answer: It is anticipated that the new SIPUs will be located at VAMCs Salem, VA; New Orleans, LA; Waco, TX; and West Los Angeles, CA. They should be designated for activation by April 1990. Each of these sites has a significant number of veterans with PTSD and a need for inpatient PTSD services as identified through MEDIPP.

Question: 3. Has VA identified any areas in which Vietnam veterans with PTSD are not receiving treatment for their PTSD?

Answer: It is not possible to identify when treatment is not being provided. One can only look to the database to determine what inpatient treatment is being provided at which VAMCs. Between 65% and 69% of discharges of patients with PTSD between FY 1986 and FY 1989 has been from VAMCs without SIPUs. The current VA database does not record outpatient care by diagnosis and so there is no routine way of documenting the level of PTSD outpatient care provided. The Special Committee on PTSD, supported by MH&BSS, plans to carry out a special survey of outpatient PTSD treatment services in September-October 1990 to replicate the FY 1986 outpatient survey reported in the Third Annual Report on PTSD.

Question: 4. To date, how many and which facilities have submitted acceptable proposals to operate PTSD clinical treatment (PCTs) teams but have not received funding?

Answer: In FY 1989, sixty VAMCs submitted proposals for PCTs that were approved by their Regional Planning Boards but were not funded. A list of these VAMCs is attached. From this group the FY 1990 PCTs will be designated based upon their initial submissions as well as updated information that is currently being submitted by the stations.

FACILITIES THAT SUBMITTED PCT PROPOSALS IN FY 1989
BUT WERE NOT SELECTED AT THAT TIME

PCT'S RECEIVED

FACILITY	REGION	MD
ALBANY	1	2
BROCKTON	1	1
BROOKLYN	1	3
BUFFALO	1	2
NORTHPORT	1	3
NEW YORK	1	3
PROVIDENCE	1	1
SYRACUSE	1	2
TOGUS	1	1
WEST HAVEN	1	3
WHITE RIVER JUNCTION	1	1
BUTLER	2	2
CLARKSBURG	2	5
COATESVILLE	2	4
LYONS	2	4
PERRY POINT	2	6
PITTSBURGH (HD)	2	5
WASHINGTON, D.C.	2	6
WILMINGTON	2	4
BAY PINES	3	12
BIRMINGHAM	3	10
COLUMBIA, SC	3	9
LEXINGTON	3	11
LOUISVILLE	3	11
MEMPHIS	3	11
MIAMI	3	12
MONTGOMERY	3	10
MURFREESBORO	3	11
NASHVILLE	3	11
TAMPA	3	12
TUSCALOOSA	3	10
TUSKEGEE	3	10
ALLEN PARK	4	14
BRECKSVILLE	4	13
CHILLICOTHE	4	13
MARION, IN	4	15
MILWAUKEE	4	16
NORTH CHICAGO	4	17
CHEYENNE	5	23
FORT HARRISON	5	23
FORT MEADE	5	23
KNOXVILLE	5	22
SALT LAKE CITY	5	23
SHERIDAN	5	23
ST. CLOUD	5	18
ST. LOUIS	5	21
TOPEKA	5	21
FRESNO	6	26
HONOLULU	6	26
LOMA LINDA	6	25

FACILITY	REGION	MD
PORTLAND	6	27
WALLA WALLA	6	27
WEST LOS ANGELES	6	25
AMARILLO	7	24
FAYETTEVILLE, AR	7	19
LITTLE ROCK	7	19
OKLAHOMA CITY	7	19
PHOENIX	7	24
SHREVEPORT	7	19
WACO	7	20

Question: 5. What component within VHS&RA is responsible for evaluating the access to care for Vietnam veterans with PTSD and by what methods is this evaluation carried out?

Answer: Readjustment Counseling Service and Mental Health and Behavioral Sciences Service are responsible for systematically evaluating all issues regarding access to care for Vietnam veterans with PTSD depending upon where the veteran applies for care. The methodology consists of the systematic review and assessment of all existing services and workload data, clinical and psychosocial epidemiological findings in the NVVRS, and available demographic data regarding the geographical distribution of Vietnam veterans. All factors are being analyzed regarding implication for and impact on existing VA programs and resources.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

APR 5 1990

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are the responses for the record to the post-hearing questions you submitted on behalf of Senator Cohen and yourself in your letters of February 23 and 28, 1990. The remaining questions submitted in your letter of March 8, 1990 are in the review process. We are making every effort to expedite these responses, and will provide them as soon as possible.

Please let me know if we can be of further assistance.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosures

EJD/map

SENATOR CRANSTON

Question: 1. Since medical centers are turning away category B and C veterans due to ongoing budget constraints, it seems reasonable to conclude that FY 1991 will see fewer days of inpatient care and fewer outpatient visits from these veterans. Yet, calculations for FY 1991 collections of copayments for such stays and visits as described in your answer to pre-hearing question 12(B) are based on earlier, non-specified years utilization by B's and C's. Do you consider these FY 1991 copayment collection estimates to be fully accurate given the decline in care to B and C veterans?

Answer: In FY 1991, VA would treat more patients than cared for in FY 1989 and FY 1990. We believe the copayment estimates accurately reflect potential collections based on the assumptions available at the time the President's Budget was developed.

Question: 2(A). Are there any approved Geriatric Research, Education and Clinical Center (GRECC) applications pending? If so, for which VAMCs?

Answer: There are no approved GRECC applications that are currently pending.

Question: 2(B). What would be the cost of establishing GRECCs in FY 1991 at all sites that have pending applications, separately as to those approved and not approved?

Answer: There are no pending GRECC applications at the present time. In order to expand the GRECC program, VA would need approximately $2.4 million per new GRECC.

Question: 3. Regarding the extent of resources needed to meet fully the estimated numbers of veterans with AIDS for whom AZT might be prescribed and as an extension of the AIDS-related question at the hearing:

3(a). How many HIV-positive veterans does VA now provide with AZT?

Answer: There is no data available on the number of HIV-positive veterans which VA now provides with AZT. However, it is assumed that at this time the number of asymptomatic HIV-positive patients on AZT is relatively small since current FDA approval is for symptomatic HIV infected patients who have had Pneumocystis carinii pneumonia or have an absolute CD4 (T4 helper) lymphocyte count of less than 200.

Question: 3(b). What is your estimate of the number of additional HIV-positive veterans currently served by VA who would be eligible for AZT under the asymptomatic approach discussed at the hearings?

Answer: In the FY 1988 Patient Treatment File (PTF), the most recent year for which complete figures are available, there were 1,743 HIV+ individuals receiving care, in addition to 611 ARC patients and 2,740 AIDS patients. These figures do not include those seen only as outpatients, although 1989 figures will when they are available within the next several weeks. We estimate that there will be a 50% increase in workload in FY 1990 so that the HIV+ individuals could number 2,615. If half of these patients had CD4 cell counts below 500 and use of AZT's approved by FDA for these patients, then 1,307 would be "eligible" for AZT. A Therapeutics Advisory Group has been established to advise VHS&RA on this and related issues. Three members will be attending the State of the Art Conference on AZT Therapy for Early HIV Infection sponsored by the National Institute of Allergy and Infectious Disease. The goal of the conference is the development of specific recommendations for the use of physicians who care for persons with early HIV infection. Those recommendations along with any actions of the FDA will be used in forming VA policy on AZT use.

Question: 4. In connection with the recent VA Inspector General's audit of third party collections -- mentioned at the hearing -- VA Billing Service of amounts that could be billed and then collected were referenced.

4(A). How were these estimates produced and under what assumptions?

Answer: The Office of the Assistant Secretary for Finance and Planning applied data from the VA Medical Center, Martinsburg to determine the national collection goals. This goal was determined by establishing a 60% collection rate which resulted in the $394 million dollar collection total.

Question: 4(B). Are these the same estimates you reached using the Martinsburg, West Virginia, VAMC experience as a guide?

Answer: These are the same estimates reached using the Martinsburg experience as a guide.

Question: 4(C). Martinsburg certainly seems to have been the most successful in its collection efforts. Was its situation in some way atypical, in that its experience could not be generalized to other facilities or to different time periods?

Answer: The Martinsburg experience can be attributed to the full support given to the Medical Care Cost Recovery program by the Medical Center Director and other staff. The Regional Director gave the medical center three additional FTEE to support the billing program, and the medical center added two FTEE for a total of five FTEE to establish a billing unit. The medical center has also developed some computer enhancements to assist with tracking any potential billing case. We believe the Martinsburg experience can be exported to other VA facilities if the proposed funding arrangements for collection costs can be implemented.

Question: 4(D). Could you please ask the Inspector General to verify that Martinsburg's situation is not somehow atypical, given the IG's audit experience in this field?

Answer: The Inspector General believes that the Martinsburg situation is only atypical in terms of the commitment given in attempting to identify and collect third party billings. Martinsburg management decided they wanted to lead in this area and did so by committing specific Medical Administration Service (MAS) resources to identify and bill veterans covered by private medical insurance. Then MAS effectively coordinated collection activities with the station's Fiscal Service. We know of no demographic reasons (e.g. station size, location, mix of patients, etc.) which would cause Martinsburg to effectively collect more third party billings than other VA stations.

Question: 5. How many scholarships were granted for nursing and other approved health-discipline degree programs in FYs 1988 and 1989 and how many are planned for the current fiscal year and for FY 1991?

Answer: In 1988, scholarships were awarded to 304 nursing students and 47 physical therapy students enrolled full-time in baccalaureate and master's programs. In 1989, nursing students received 350 awards, and 44 were awarded to physical therapy students.

It is anticipated that in FY 1990 at least 279 scholarship will be awarded to nursing students and 63 to other approved health disciplines. However, the implementation of scholarships for associate degree nursing students will result in the final number of awards being significantly higher, probably about the same as awarded in 1989.

The current estimates for FY 1991 are 328 awards to nursing students and 70 to other health disciplines.

Question: 6. How many category A, B, and C veterans were admitted for inpatient care in FY 1989? How will the numbers or the relative proportions change in FY 1990? In FY 1991?

Answer: The number of admissions by means test category are not available. The actual discharges for Fiscal Year 1989 by means test category are listed below:

Means Test Category	Discharges
Category A - SC	410,019
Category A - NSC	546,144
Category B	23,975
Category C	14,766
Non-Veterans	6,034
All Other	4,857
Total	1,014,795

It is felt that these proportions will remain relatively constant in FY90 and 91.

Question: 7. Please provide details on how the $20 million provided by the Department of Defense in FY 1990 for "research projects that will be beneficial to both Agencies" will be used (budget books pages 7-7).

Answer: Of the $20 million provided by the DoD for FY 1990, $11 million along with $7.5 million from prior FY DoD funds will be used to support VA/DoD programs in FY 1990 which are also VA merit approved research programs. The remaining $9 million will be carried over into FY 1991 to partially support these programs in FY 1991. In general, merit reviewed research programs are funded for three years. Therefore, commitments to fund programs in FY 1989 and FY 1990 will require funding into FY 1992.

Question: 8. The response to pre-hearing question 51 outlined the reasons for the realignment of 428 nursing positions from hospital to nursing bed responsibilities in FY 1991 and listed the facilities that would be affected. What is the anticipated impact of the loss of 428 nursing FTE from the hospital functions they had been performing at the affected institutions?

Answer: 8. The budgeted nursing realignment simply projects that there will be a shift in resources from hospital to nursing home activities. This occurs at individual VAMCs with scheduled nursing home projects that have been budgeted in prior fiscal years but activation is delayed to 1991 (see example below). The estimated FTE to be realigned is based on the current staffing ratio per nursing census and represents not only registered nurses but the full mix of employees required for complete nursing care. The facilities included in this shift of resources from the hospital activity to the nursing activity are San Juan, Philadelphia, Prescott, Chillicothe, Batavia, Canandaigua, Butler and Walla Walla. The decrease in hospital beds partially results from the realignment but also reflects fewer beds due to census reductions, and the increasing turnover and shorter length of stays of patients.

HYPOTHETICAL EXAMPLE

Assume the 1990 President's Budget requests all the FTE and dollars to support a new 120 bed nursing home in ABC VAMC. The Budget also projects that, in total, activations will slip 25 percent prior to activation. If one applied the 25 percent to this project and added the 1990 slippage in 1991, the average operating beds funded in the 1990 Budget would be:

1990 Budget	1990	1991	Increase
Average Operating Beds...	90	120	+30 (25% of 120 Beds)

In formulating the 1991 Budget we find the project (according to latest construction timetables) will activate in 1991. It is assumed that the 1990 budgeted resources supporting the 90 beds will be utilized in the ABC VAMC's hospital activity (not nursing).

The 1991 Budget will request resources supporting 30 beds (1990 slippage into 1991) and realign (shift) resources (equivalent to 90 beds) from the hospital activity to the nursing activity as originally intended.

1991 Budget	1990	1991	Increase
Average Operating Beds...	...	120	+120 (+30 beds thru slippage and +90 beds thru realignment.

Question: 9. I congratulate the Department for considering the total work environment in seeking to improve nurse recruitment and retention, as described in the answer to pre-hearing question 15. Is it correct that your proposal to hire 798 extra nurses by instituting the elimination of required shift rotation is achievable only if special pay legislation is first enacted?

Answer: The Administration proposed eliminating shift rotation as one of a number of measures which has merit on its own for enhancing recruiting and retention. The additional FTEE requested, by enabling VA to have constant shifts, will itself make VA more attractive and help recruiting and retention. Nurse pay reform, currently being developed, will work in tandem with the ending of shift rotation to improve VA's competitiveness, but each has its own enhancing effect, and we believe neither depends totally on the other.

Question: 10. Table 10 of the Independent Budget document presents the number of research merit review proposals and the number funded for FYs 1984 through 1990.

10(A) Is this table accurate?

Answer: There are slight differences between Table 10 of the Independent Budget and those reported by VA in the following table.

Merit Review Proposal Results
1984-1990

Fiscal Year	Total Reviewed	App. & Funded	App. & Not Funded	Award* Rate(%)	% Funded (of total)
1984	988	586	107	84.5	59.3
1985	1,039	630	139	81.9	60.6
1986	1,177	722	175	80.5	61.3
1987	1,219	672	335	66.7	55.1
1988	1,305	630	448	58.4	48.2
1989	1,320	471	712	39.8	35.6
1990	1,292	539	649	45.3	41.7

*Award Rate (%) - percentage of those approved which are funded

Question: 10(B). What do these figures portend about the commitment to VA-based research and VA's ability to use research funding in physician recruitment and retention?

Answer: In FY 1991, the President's budget requested increases for Rehabilitation by $1,139,000 over FY 1990 and almost $4 million over FY 1989. The budget request for FY 1991 for Health Services Research is $1,021,000 over FY 1990 and $900,000 above FY 1989. The request for FY 1990 and FY 1991 does represent a shift in emphasis from Medical Research to Rehabilitation Research and Health Services Research with an overall decrease in the total Medical and Prosthetic appropriation of $14,115,000 and a decrease of $16,275,000 for Medical Research.

If the proposed budget reduction for 1991 is made, no new medical research programs will be funded and some ongoing studies will be terminated. As a result, we would expect a negative effect on the retention of some current medical personnel.

Question: 11(A). Your answers to my prehearing questions 31(A), (B), and (C) indicate that VA estimates its total expenditures on treating drug abuse by considering that 9.8 percent of all VA patients have a primary or secondary drug-abuse diagnosis, and then calculating what the cost would have been to treat these patients in a substance-abuse unit. Thus, the figures contained in the budget do not actually reflect VA's expenditures on treating patients for their drug problems specifically, but rather the best estimate of VA's total hypothetical cost of treating these patients in specialized drug-abuse programs; is that correct?

Answer: Yes, that is correct.

Question: 11(B). Because you were able to come up with such an estimate for VA's system-wide expenditures on drug treatment, I assume you can do a similar estimate on the portion of medical care funds that are spent on mental-health treatment. Please provide such an estimate for each of FY's 1989, 1990, and 1991.

Answer: Total Mental Health treatment expenditures for 1989-1991 are estimated in chart below:

(Dollars in Millions)

1989	1990	1991
$1,463	$1,542	$1,674

The 1989 expenditures were determined by using the VA's Cost Distribution Report to include both inpatient psychiatric bed section obligations and outpatient mental health (including direct care, indirect care and asset acquisitions). These obligations include a wide variety of mental health programs including general and specialized psychiatric care, PTSD, Drug and Alcohol Dependency Treatment Programs, Day Treatment, Day Hospital, Mental Hygiene, etc.

Changes in 1990 and 1991 include Congressional add-ons (e.g. PTSD, HCMI and Drug and Alcohol increases in 1990), sequestration reductions (in 1990) and budgeted increases in 1991 (e.g. inflation, payroll increases and budget initiatives in drug abuse treatment).

Question: 12. Please tell us what portion of the $957 million increase in FY 1991 for medical care will be devoted to mental-health care.

Answer: It is estimated that approximately $140 million of the $957 million requested increase to Medical Care proposed legislation will be devoted to mental-health care.

Question: 13. Please provide for the record the number of psychiatrist vacancies that exist, list those sites at which more than one such vacancy exists and those sites at which a vacancy has been unfilled for more than six months, and show the total FTE ceiling for psychiatrists at each such facility.

Answer: The following is a list of psychiatrist vacancies that exist:

FACILITY	TOTAL VACANCIES
Albany, NY	2
Albuquerque, NM	2
Allen Park, MI	5
Altoona, PA	2
Battle Creek, MI	2
Brooklyn, NY	2
Buffalo, NY	3
Canandaigua, NY	2
Chillicothe, OH	3
Cleveland, OH	2
Coatesville, PA	5
Dallas, TX	2
Decatur, GA	4
Fargo, ND	2
Gainesville, FL	2
Knoxville, TN	2
Lebanon, PA	2
Lexington, KY	3
Little Rock, AR	3
Marion, IN	2
Minneapolis, MN	4
Mountain Home, TN	5
Murfreesboro, TN	4
Northampton, MA	2
Northport, NY	3
Oklahoma City, OK	4
Omaha, NE	2
Perry Point, MD	2
Pittsburgh, PA	2
St. Cloud, MN	2
Sheridan, WY	2
Sioux Falls, SD	2
Wilkes-Barre, PA	2

Those facilities which have had at least one vacancy for six months or more were:

Albany, NY
Allen Park, MI
Altoona, PA
Bath, NY
Battle Creek, MI
Big Spring, TX
Butler, PA
Decatur, GA
Durham, NC
El Paso, TX
Fargo, ND
Fort Lyon, CO
Huntington, WV
Knoxville, IA
Leavenworth, KS
Lebanon, PA
Lexington, KY
Little Rock, AR
Lyons, NJ
Marion, IN
Minneapolis, MN
Mountain Home, TN
Murfreesboro, TN
Northport, NY
Oklahoma City, OK
Omaha, NE
Perry Point, MD
St. Cloud, MN
Salem, VA
Salisbury, NC
Salt Lake City, UT
Sheridan, WY
Sioux Falls, SD
Tucson, AZ
Wadsworth, CA
Washington, DC
West Haven, CT
Wilkes-Barre, PA

We do not currently track the FTE physician ceiling at each facility centrally. The Department is in the process of implementing a new reporting system, which will provide information for each facility on a quarterly basis. The first such report should be available by the end of April 1990. We believe the vacancies may be under-reported, due to the fact that once a position has been vacant for a year or more, the vacancy may be converted to other uses. For instance, if a medical center cannot hire a psychiatrist after a year of recruitment, they may fill the vacancy with a physician assistant, or they may allow another service at the medical center, which can attract candidates to use the vacancy. These types of situations would not be accounted for in our current vacancy reports. The new reporting system is designed to improve the accuracy of these reports.

Question: 14. Under the existing Central Office standards, please provide the following information in regard to prosthetics:

(A) What is the current prosthetic backlog in dollars and in items?

Answer: The backlog in the number of prosthetic orders has been averaging approximately 1,600 orders per month for the last several months. No data is available on the number of items or dollar value of orders being held. The monthly reports submitted by the field do not indicate that the availability of sufficient funds is an issue. Most delays are being caused by administrative problems.

Question: 14(B). What will the backlog be at the end of F.Y. 1990?

Answer: Given the additional funding provided for prosthetic services for FY 1990 and the budget request for 1991, no shortfall should occur.

Question: 14(C). What will the backlog be at the end of F.Y. 1991?

Answer: See previous answer.

Question: 15. According to information compiled by the Committee's investigator, there is an inconsistency in how various medical centers are tracking the prosthetic backlog. For instance, at least one VAMC visited considers a request as being backlogged if more than 5 days transpire from when the prosthetic clerk receives the request to when the clerk forwards the request to the clerk's superior. Another medical center visited considers a request as being backlogged if more than 5 days transpire from when the prosthetic clerk receives the request to when the patient receives the prosthetic device. These are obviously very different standards.

15(A) What is your reaction to that inconsistency, do you believe it is widespread, and do you have plans to eliminate it?

Answer: Reviews of the reports of delayed prosthetic orders submitted by VA medical centers indicate some confusion and varied interpretations on the meaning of a "delayed order". This is somewhat understandable given the nature of the prosthetic appliances involved and complexities of the federal acquisition process. To resolve this issue, the Associate Deputy Chief Medical Director, the Regional Directors and prosthetic program officials are working together to better define the parameters of a delayed order. The Regional Director will issue revised guidelines to permit improved reporting by April 1990.

Question: 15(B) Since there does appear to be inconsistency used in measuring the backlog, how can we know what the true size of the prosthetic backlog really is?

Answer: Given the confusion which now exists, we cannot be sure of the accuracy of the number of delayed orders being reported. However, we are confident that revised reporting guidelines will improve the accuracy of the reports.

Question: 16. In prehearing question 10(C), which related to your proposal to assign 800 FTE to the preparation and collection of billings of health insurers, I asked which, if any, of the functions involved in that process could not be efficiently performed by contractor employees. Before asking a follow-up question, I want to emphasize that I want to work cooperatively with you, with Senators Murkowski and Graham, and with others in developing a better method for obtaining these reimbursements, and it occurs to me that contracting out this process could have two salutary effects: (1) allowing the 500 VA employees now doing the billings to return to work related to furnishing care to veterans, and (2) capitalizing on the profit motive of a private firm, whose earnings would be a percentage of its collections from the insurers.

16(A). In response to my question, you stated that most of the functions could be performed by a contractor's employees. The only function that you identified as one that VA staff must perform is the interpretation of Federal laws and regulations and VA policies, which would be the responsibility of VA legal offices.

(i). Clearly, VA counsels could continue to carry out that responsibility if the preparation and collection of billing were contracted out, couldn't they?

Answer: Yes, VA attorneys would maintain the same level of responsibility for the proper collection of recoveries even under private contracts.

Question: 16(A)(ii). Moreover, isn't it so that VA lawyers are not included in the 800 FTE who would be paid under the proposed new third-party recovery account?

Answer: Yes.

Question: 16(B). I was particularly interested in the part of your response which indicated that contracting out would seem to be a superior approach in one area -- identifying and following up with respect to patients who claim they have no insurance coverage or refuse to provide that information. You said that here the "use of a contractor's services could have a significant impact in increasing recoveries." Are you saying that the contract approach would be more cost-effective in this respect?

Answer: A contractor presented the VA with a proposal to identify insurance coverage of veterans who claim to have no health insurance. His data indicated that his prior success in private industry collections was based on the scanning of Medicare and Medicaid data bases. As you are aware VA cannot bill these entities. When queried about the use of private insurance data bases, the vendor indicated that he had access to all insurance data. The Health Care Financial Management Association located in Chicago refutes this claim saying that access to insurance data is extremely limited. We are saying that we would like to test this concept. We were advised that the medical care appropriation would have to pay for the contract. If VA could pay for a contract that would find veterans with health care insurance and the costs could be paid from the proceeds of collections received as a part of this methodology, VA would proceed with this method of identifying potential payors.

Question: 16(C) (i). Can you give this matter an expedited review and let me know the maximum extent to which the use of a contractor could be beneficial in this area?

Answer: There are GSA contractors at this moment that are ready and able to step in and provide all billing and collection services for VA. The problem VA is having is in finding enough FTEE at the reception counter to adequately review, investigate and follow-up the data provided by the veteran. The collection activity is relatively easy once the insurance carrier is identified and the requirements of the policy are met.

Presently VA would have to pay a contractor approximately 30 per cent of the collections to accomplish all aspects of this job, including identification billing and collection. A problem with having a contractor do this work is that, under current law, only the payment for the contractor's collection services may come from amounts collected. Payments for other services, such as identification and billing, must come from other sources, such as the medical care appropriation. The forthcoming legislative proposal will permit VA the flexibility to utilize either in-house or contracted-for services, whichever is more efficient, and with the costs of either approach to be defrayed from amounts collected.

Question: 16(C) (ii). Can you also ask VA staff to develop for the Committee as a technical service a contractor-oriented modification of the approach described in the budget?

Answer: VA believes that the forthcoming legislative proposal provides the flexibility to use either in-house or contracted-for services. If, upon review, the Committee wishes to develop this issue further, VA will be happy to provide, upon request, a different proposal as a technical service.

Question: 17. Dr. Gronvall recently announced a reorganization that relieved the Deputy Chief Medical Director of two responsibilities. The Medical Inspector Office was transferred to the CMD's office, and the Director of the Quality Assurance Office was renamed Assistant Chief Medical Director for Quality Assurance and transferred to under the Associate Deputy CMD. How will this new division of program oversight promote an improvement in quality assurance and quality of service, and what, if any, change in total FTE was involved?

Answer: On October 4, 1989, the Secretary approved organizational changes intended to expand and improve Veterans Health Services and Research Administration's (VHS&RA's) quality assurance and medical inspection programs, as required by Public Law 100-322, Section 201. These changes are as follows:

- Realign the Office of the Medical Inspector (OMI) from a staff office of the Deputy Chief Medical Director (DCMD) to a staff office of the Chief Medical Director (CMD);
- Realign the Office of Quality Assurance (OQA) from the CMD to the Associate Deputy Chief Medical Director (ADCMD); and
- Establish a new position, Assistant Chief Medical Director for Quality Assurance (ACMD/QA). The current position, Director, Quality Assurance, will be redesignated as ACMD/QA.

This new alignment of the OMI and conversion of the Director, Office of Quality Assurance, position to an ACMD were extensively considered by knowledgeable staff in VHS&RA and at the Department level. There was general agreement that development and implementation of QA policies and programs would be accomplished most effectively with the QA organization closely linked to program and operational elements. This linkage provides improved opportunities to involve clinical program experts in development of QA policies and programs and increases the Regional Director's (RD's) responsibility and accountability for implementation. A QA program removed from operations and clinical programs runs the risk of being theoretical and administrative and may fail to focus on the practical implications of quality (e.g., the credentialing and privileging process). For QA to be effective, "quality" must be a part of all clinical, administrative, and managerial activities of every medical center.

The Medical Inspector, under this new alignment, will function as an investigative body, performing inquiries and investigation into medical issues that may involve alleged malpractice or malfeasance. The MI reports directly to the CMD to ensure that this office remains beyond the influence of interested parties. It is equally important that the MI remain disassociated from the routine QA activities of a health care facility that focuses on correction of system problems and the constant improvement of health care delivery. The Medical Inspector has the responsibility to advise the CMD on the effectiveness of VHS&RA's overall QA activities and must be accountable to only the CMD to retain the independence and objectivity required of this role.

The Office of the Medical Inspector and the ACMD/QA have different but equally important roles. This new alignment will enable both to be more effective and to achieve the program improvements intended by Public Law 100-322. To ensure that the Medical Inspector and ACMD/QA effectively execute their responsibilities, and to comply with requirements of the law, a total of 10 FTEE have been assigned to these offices. Because of their importance, additional resources have been allocated to these programs despite overall cutbacks in MAMOE staffing.

Question: 18. In response to informal questions posed by the Committee on February 1, VA estimated that the Vocational Rehabilitation and Counseling program would have to be increased by 73 FTE in FY 1991 to achieve an average time in applicant status of 60 days and an average time in employment services of 200 days.

18(A). Do you expect that projected military strength reductions will increase demand for vocational rehabilitation counseling?

Answer: The specific number and type of military strength reductions are not known in sufficient detail to permit projection of personnel requirements. VBA is attempting to secure the information from DOD which would make such projections possible.

Question: 18(B). If so, were anticipated troop reductions taken into account in computing the figure of 73 additional FTE? If not, could you provide for the record the additional counseling FTE and contract counseling resources needed to meet the needs of such additional numbers of new veterans?

Answer: The strength reductions were not considered in developing the FTEE requirements in the 1991 budget. In view of the lack of specific information concerning strength reductions, it is not possible to develop meaningful FTEE requirements. We would be pleased to provide such information to you as soon as we have it.

Question: 19. A January 4, 1990, front page New York Times article, entitled "U.S. Orders Savings Agency to Sell Seized Property Fast", describes the economic impact of the sale of real estate and other assets now held by the Resolution Trust Corporation (RTC). What effects on VA's home loan program could result from a rapid sell-off of assets held by the RTC?

Answer: Any significant increase in the supply of real estate in most areas of the country, without a corresponding increase in demand, will depress real estate values in the affected areas even further. If the RTC should decide to rapidly sell-off its acquired residential property assets, VA would probably experience higher foreclosures in some areas and would have to accept lower prices for our properties in order to compete for buyers with the other sellers of foreclosed properties in the marketplace.

However, the Financial Institution Reform, Recovery, and Enforcement Act of 1989 (FIRREA) includes several provisions which are intended to prevent the RTC from drastically disrupting real estate markets. First, the RTC is required to offer any single family property appraised at $67,500 or less to individuals in the low and moderate income categories for 90 days prior to making it available for sale to the general public. Second, the RTC is prohibited from selling properties to the general public for less than "95% of market value". Third, the law forbids the RTC from "dumping" properties in states such as Texas, Oklahoma, Colorado and Louisiana. In most areas of the country, especially in these states, there is already an existing imbalance between real estate supply and demand. These are also the states where the RTC has the most residential properties. Over 46% (14,000) of these properties are in Texas.

Question: 20. Please provide both a copy of the Federal credit policy guideline governing the budget scoring of VA vendee loans and a description of the rationale behind the guideline, including an explanation of the difference from the scorekeeping of a cash sale of a VA-owned property.

Answer: Attached for your information is the OMB Circular A-129, "Managing Federal Credit Programs". Please refer to Appendix 6 for specific information regarding the Administration's position on loan asset sales.
(OMB Circular A-129 is retained in the committee files.)
Under current law there is no difference between scoring relative to these guidelines and a cash sale of a VA-owned property. Upfront receipts from both sales of loans and cash sales of VA-owned properties are recorded as offsetting collections.

As you know, the FY 1991 budget reflects estimated receipts from partial-recourse VA loan sales as offsetting collections pursuant to P.L. 101-237 (Section 305) which was enacted December 18, 1989. Prior to this legislation, a scoring convention agreed to between CBO and OMB provided that proceeds from recourse loans would be scored as budget authority for budget purposes in order to reflect the government's liability inherent in recourse sales.

Question: 21. An Associated Press article that appeared on February 20, 1990, in the New York Times and other papers quoted VA's Loan Guaranty Service Director as having stated at a House hearing last April that the default rate of 11 percent, which was the rate VA assumed in making its current budget proposals concerning the home loan program, is unrealistically high for projecting defaults in the 1990's. At the same time, however, he is quoted as saying that the generally optimistic economic projections underlying the overall Bush budget do not apply to the VA home loan program. How do you reconcile your pessimistic numbers with the very optimistic economic projections assumed in every other part of the President's budget?

Answer: The Associated Press article is not an accurate description of the information provided to the AP by Mr. Pedigo regarding the President's economic assumptions. The reference to the statement by Mr. Pedigo at the House hearing in April 1989 is correct but needs further explanation.

In March 1989, Peat Marwick Main & Company completed an actuarial analysis of selected VA housing benefits and alternative sources of funding in support of those benefits. As Peat Marwick was finalizing its report, Loan Guaranty Service staff had numerous discussions with the contractor concerning foreclosure assumptions. In general, the staff felt that Peat Marwick was placing too much emphasis on recent foreclosure experience which in turn caused the costs of various alternative benefits to be too high. When asked at the April, 1989 hearing to express a personal opinion about the foreclosure rates used in the Peat Marwick study, Mr. Pedigo responded that a 7 to 8 percent foreclosure rate would probably be more realistic. Mr. Pedigo's response was not intended to be a definitive estimate that would represent the basis for Loan Guaranty Service's FY 1991 Budget submission. Although he did not state it as such, certainly this level of foreclosures is a goal we should strive to obtain.

Secondly, the statement in the Associated Press article that Mr. Pedigo insisted that the economic projections underlying the President's budget submission do not apply to the loan program is not a fair representation of the information provided to the reporter from AP. It was explained to the reporter that the major economic assumptions supporting the budget should not be the sole basis for formulating the program's budget submission. This does not mean that these economic assumptions are inaccurate. Mr. Pedigo pointed out that during the 1980's, inflation and unemployment have been kept at low levels. However, VA has experienced the highest levels of foreclosures in the program's history. He stated that it was important to look beyond the broad national economic assumptions to the strengths of regional economies relative to overall home loan activity in those areas, as well as historical program performance. Also, VA considers the manner in which policy and regulatory changes may influence future origination, foreclosure and property management workloads. Therefore, the Loan Guaranty Program budget ultimately takes into account a number of economic and specific program factors.

Question: 22. What are the budgetary effect and policy implications of combining the Direct Loan Revolving Fund (DLRF) with the GIF or with the LGRF?

Answer: The 1991 budget submission includes a proposal to merge the DLRF with the LGRF. The proposal identified budget authority and outlay savings of $26.7 million and $14.1 million respectively in the LGRF with a corresponding outlay offset in the DLRF. There is no net budgetary effect from this proposal. There are no apparent policy implications because the proposal assumes the continuation of the direct loan program as it's currently authorized in the 1990 appropriations bill. Only the accounting of obligations, budget authority and outlays will be impacted through consolidation. The merger was proposed only because of the low level of direct loan activity and the desirability of submitting one VA housing budget for loans made prior to the establishment of GIF.

If there were a merger of DLRF with GIF instead of the LGRF, the effects would be the same as those described for the LGRF merger. However, the $26.7 million in unobligated balances from DLRF would not be available to the LGRF.

Question: 23. Please describe the legal basis of the $1.7 billion "liability" of the DLRF, which VA is seeking to eliminate through a technical amendment as part of the Administration's proposed legislation.

Answer: The Direct Loan Revolving Fund (DLRF) was established by section 513 of the Servicemen's Readjustment Act of 1944, as added by the Housing Act of 1950, ch. 94, § 301(h), 64 Stat. 48, 75-77. Section 513(a) authorized and directed the Secretary of the Treasury to advance to VA up to $150 million for making direct loans. That section further provided that "[a]fter the last day of which the Administrator may make loans under...section [512], he shall cause to be deposited with the Treasurer of the United States, to the credit of miscellaneous receipts" certain moneys held or received in connection with the direct loans. Section 513(c) further provided that "not later than June 30, 1952, [the Administrator]...shall cause to be...deposited [to miscellaneous receipts in the Treasury] all sums in said account, and all moneys received thereafter" from direct loans.

Section 513 of the Servicemen's Readjustment Act was subsequently recodified as 38 U.S.C. § 1823. Although new advances were authorized and deadlines extended and, ultimately, repealed, the basic law remained generally as originally enacted. Section 1823(c) of title 38 still requires the Secretary of VA to deposit, to the credit of miscellaneous receipts, "such of the funds in such account as in the Secretary's judgment are not needed for the purposes for which they were provided..."

On July 17, 1989, the Chief Counsel of the Financial Management Service, Department of the Treasury, issued an opinion that "the Veterans Administration is required to repay amounts advanced by the Secretary of the Treasury to the DLRF, i.e., $1.7 billion. Section 513...contains no authority allowing waiver of the amounts advanced. In the absence of such authority, no one is authorized to waive a claim owing to the United States."

Question: 24(A). Please explain the rationale for VA's credit standard that allows a borrower's total debt to constitute as much as 41 percent of the borrower's income, compared to 36 percent for conventional-loan standards.

Answer: The debt-to-income ratio is one of several important factors considered when underwriting a VA loan application. Residual income is the most important factor in determining the sufficiency of a veteran's income; i.e., the amount left over after gross monthly income is reduced by taxes, monthly debt payments, and the shelter expense for the home to be purchased, including maintenance and utility estimates. The 41 percent ratio is a standard above which an increased level of risk associated with the loan must be recognized. Amounts up to such a guideline are generally considered to be typical debt levels for homeowners.

The rationale for selecting a guideline figure in excess of that used in some conventional underwriting standards included, first, that in light of the secondary consideration given to the ratio in underwriting VA loans, it was necessary to establish a guideline which would, while giving proper consideration to assessment of risk, continue to enable veterans to qualify for loans they are financially capable of repaying. Secondly, we considered that most conventional loan standards discount obligations with 10 or less payments remaining when computing the ratio, while VA counts all debts with six payments or more. Even then, VA standards call for counting even shorter term debts if the payment amount is a substantial one.

It is significant to note that HUD has recently increased its debt-to-income ratio from 38 percent to 41 percent. In doing so, the agency noted that their analysis indicated that 38 percent was too low and 41 percent would make HUD consistent with VA.

Question: 24(B). Please describe any modifications to this or other income-to-debt ratio standards that VA is currently considering and the status of any proposal VA expects to make concerning these modifications.

Answer: There is no current consideration being given to changing the basic guideline of 41 percent. Recently published proposed regulations provide additional processing guidelines for loans exceeding 41 percent, as well as loans that meet the 41 percent guideline but not the residual income guideline. Loans needing additional justification for approval, including a listing of specific compensating factors considered, are those in which the ratio is 41 percent or less but residual income standard is not met, or those in which the ratio is 42 to 45 percent and the residual income is met, or those in which the ratio is 46 to 50 percent and the residual income is exceeded by 20 percent or more. Loans not falling into these categories must be submitted to VA for prior approval processing and must include the lender's explanation as to why the lender believes the loan is approvable.

Question: 25. Page 32-5 of the VA budget documents discusses the statutory requirement that VA include interest and administrative costs in a veteran's debt for compensation and pension overpayments. VA states that it will prepare and submit legislation to the Congress in 1992 that would exempt such debts from interest and costs.

(A). Please describe the state of VA's current compliance with the statutory requirement that it include interest and administrative costs in a veteran's debt for compensation and pension overpayments.

Answer: VA is not currently charging interest or administrative costs on compensation and pension overpayments. In the enactment of the Debt Collection Act of 1982, which authorizes the charging of interest and administrative costs, VA made the determination to initiate interest charging on education debts first since they comprised the majority of VA debt at that time. The plan was to follow with interest charging on C&P debts after that initiative was completed. It required a two-year ADP effort to implement interest charging on education debts. At that point, OMB was urging Agencies to implement other collection initiatives which were also authorized by the Debt Collection Act of

1982 but provided a larger payback. These included the IRS Income Tax Offset Program, the Federal Offset Program, Referral to Private Collection Agencies, and Referral to Credit Reporting Agencies. Legislative proposals were prepared in 1988 and 1989 requesting exemption from charging interest and administrative costs on these debts. The proposals required further evaluation within the Administration as is addressed in question C that follows.

Question: 25(B). What is VA's experience with waiver applications specifically covering interest and costs?

Answer: Interest and costs accruing after VA establishes a debt for collection purposes are not subject to separate consideration for waiver of collection. To warrant waiver, a VA committee on waivers and compromises must first conclude that the underlying debt was not the result of the debtor's fraud, misrepresentation or bad faith. If these factors are not demonstrated, the committee next considers whether equity and good conscience warrant waiver of the total debt, including principal, interest and administrative costs. As stated in VA's financial policy manual, if a debt is waived or cleared by corrective award action, any accrued interest and costs are also waived or cleared.

In certain requests for waiver of loan guaranty debts, a committee on waivers and compromises may consider whether interest and costs accruing after default but before foreclosure may be subject to waiver of collection if the loan holder waited an excessive period before proceeding with foreclosure. VA does not establish a debt for collection purposes until after foreclosure or a property title has otherwise been transferred from the debtor.

Question: 25(C). Why does VA plan to wait until 1992 to submit proposed legislation?

Answer: VA has submitted legislative proposals to the Office of Management and Budget (OMB) regarding this issue. As the result of objections from the Department of Education (ED), however, OMB has not approved this proposal. ED's objections have been grounded on their position that an exemption from interest charging in our program would have an adverse impact government wide on Federal debt management programs. VA intends to resubmit the legislative proposal for OMB's approval in 1991. As we have in the past, we shall thoroughly address ED's objections.

Question: 26. In testimony before the House Committee on Veterans' Affairs on February 6, 1990, Secretary Derwinski said "we intend to pursue additional management reforms in all our organizations in the coming months. This year, we will take steps to improve the organizational structure within our central headquarters here in Washington."

26(a). Please describe the "additional management reforms" to which the Secretary referred.

26(b). Please describe the Central Office reorganization to which the Secretary referred.

Answer: Since the elevation of the VA to cabinet-level status, significant reorganizations have been approved. To complement these reorganizations, a review will be conducted of the functions and staffing levels of all VA Central Office administration and staff office organizations and field components of staff office organizations. The review will be conducted by teams consisting of staff from organizations undergoing review with technical support from Department personnel and management analysts. The purpose of this effort is to do an objective assessment of each organization's functions and corresponding staffing levels in relation to that organization's mission and future direction of the VA. This will assure that organizations are structured and staffed to accomplish their missions in an effective and efficient manner.

Question: 27. Your response to prehearing question 7 asserted that the FY 1991 budget "should have no adverse effect on the Federally chartered advisory committees".

27(A). Does that mean that you have requested enough money in the MAMOE, GOE, and Medical Research accounts to allow the 34 V.A. advisory committees to meet as often as the committees themselves believe, or as statutory responsibilities?

Answer: When determining what to budget for the 34 VA advisory committees in FY 1991, the Department based its estimates on our 1989 experience and budgeted accordingly. An advisory committee's charter and/or official to whom the committee reports generally dictates the number of meetings to be held.

Question: 27(B). Did you ask the advisory committee chairpersons to tell V.A. staff how often they plan to meet in FY 1991 and what other costs they predict their particular committee will incur?

27(C). [If so,] Could you please provide copies of each committee chairperson's response and a description of the amount of expenses covered in the budget request as compared to the Committee chairperson's request?

Answer: No formal request was made for the chairperson's opinion as to the number of meetings that should be held in 1991 or the costs to be incurred. Funding requirements have always been based on prior year experience and estimated need. Any additional costs not anticipated will be absorbed by the VA.

Question: 28. Please state how many additional FTE you would need in VBA in FY 1991 in order to achieve during that year at all Regional Offices timeliness standards of 90 percent for each of the 22 end products identified in your response to pre-hearing question 33.A. to which timeliness is relevant and for which the FY 1990 standard is less than 90 percent. Please include in your answer a verbal description of each end product.

Answer: Of the 14 C&P end products currently measured for timeliness, five are at or above 90 percent timeliness levels. They are:

EP 130	Dependency issues
EP 150	Income issues
EP 155	Eligibility Verification Report Referrals
EP 310	Reviews including Future Examinations and Unemployability
EP 320	Reviews due to Hospitalization

The remaining nine end products are listed below:

EP 110*	Initial Disability Compensation
EP 180	Initial Disability Pension
EP 140	Initial Death Compensation and Dependency Indemnity Compensation
EP 160	Burial, Plot, Headstone or Marker Engraving
EP 120	Reopened or Supplemental Claims
EP 290	Eligibility Determinations
EP 600	Predetermination Notice Case

* Critical path for finalizing this EP is contingent on obtaining service medical records from the Service Department.

In order to attain 90 percent completion rates in the established time frames for these nine end products, we project an additional 84 FTE will be needed. In arriving at this figure, we determined the number of additional completed claims per end product type which would be needed to raise the completion rates to the 90 percent goal level. The work rate standard for each applicable end product was multiplied by the additional cases per end product to determine the standard man hours needed which was then divided by 260 days times eight hours. This resulted in 84 additional FTE.

Assuming new employees will become more knowledgeable about claims processing and procedures and productivity will increase, no significant increase in FTE will be required in FY 1991 to meet a timeliness standard of 90 percent for education claims processing.

A brief description of education end products follows:

EPC 200 - Original applications for education benefits under chapters 30, 32, or 35 of title 38 and chapter 106 of title 10, United States Code.

EPC 210 - Supplemental applications involving a change of facility or program, reentrance into training, change of training time, request for counseling and other related actions.

EPC 220 - Claims involving mitigating circumstances.

EPC 230 - Dependency determinations; eg., additional benefits payments for a veteran's dependents.

EPC 240 - Unsatisfactory progress and delimiting date extensions where veteran lacks high school diploma or GED.

EPC 250 - Extended delimiting date determination (disability).

EPC 260 - Education loan.

EPC 270 - Notice of disagreement.

EPC 280 - Second change of program.

Question: 29(A). On January 11, 1990, you created and filled the new position of Deputy Assistant Secretary for Security and Law Enforcement, and located the new and expanded program in the office of the Assistant Secretary for Human Resources and Administration. You noted that, in addition to the security services in VHS&RA and Central office, other security-related functions were under review and may be transferred.

29(A). What other functions are contemplated, and how many FTE will be involved altogether?

Answer: Thus far, the functions transferred to the Deputy Assistant Secretary (DAS) for Security and Law Enforcement include oversight of VHS&RA police and security operations, Central office security, the Police Training Center, and Departmental emergency planning. We are reviewing other functions for possible transfer to the DAS. However, no transfers are contemplated at this time. Because our review is continuing, we are unable to identify how many FTE may be ultimately involved.

Question: 29(B). How many of these will be simply transferred positions consolidated into a centralized organization, and how many represent new FTE positions?

Answer: Fourteen positions have been transferred to the DAS for Security and Law Enforcement to carry out the oversight of VHS&RA police and security operations, and the CO security, Police Training Center and emergency planning functions.

Question: 29(C)(I). From what account will the new positions be paid?

(II). From what accounts currently are the positions in the new office paid?

Answer: For the current fiscal year, positions are being paid from a combination of accounts including GOE, MAMOE, and Medical Care. Next fiscal year all positions will be paid from GOE.

Question: 30. I noted that under the minor construction projects for FY 1991 there was a request for $8.3 million for staff offices, including those in the Central Office. Under the major construction projects, however, there was a request for $22 million to renovate the main Central office building. What, if any, is the connection between these two requests?

Answer: There is no connection between the two requests. The major project is a one time request to renovate the main Central office building. The General Services Administration is planning this project for FY 1991 to upgrade all utilities. The GSA project will totally disrupt the building, both physically and operationally. In accordance with the building delegation provisions of GSA, VA must fund certain costs of its office space. The requested funding is for new interior construction which will mesh with the planned GSA project and will capitalize on the demolition of spaces for utility upgrading and renovate these areas in conjunction with the work done by GSA.

The minor project line item covers numerous staff offices, whose facilities are primarily located nationwide (e.g. the Office of Information Resource Management, General Counsel, the Office of Acquisition & Management, Office of the Inspector General, etc.). Only a small percentage of the total minor project cost will be used to renovate those staff offices in Washington. Planned Central Office work for these staff offices includes incidental repairs, installation of additional outlets, touch up painting and other work of a minor nature. All (minor project) work requested for the main building is scrutinized to ensure that it is essential, needed prior to and not duplicated by the major project.

Question: 31. I am concerned with the quality of service being provided to the public through the VBA regional office telephone interview activity. At many offices the public gets a busy signal over 30 percent of the time that a phone call is made because there are not enough telephone lines going into the phone unit. Based on today's hearing testimony, some of this is apparently due to local managers being concerned that they do not have enough staffing to provide for all the lines that are needed. The Independent Budget suggests that adding more lines and people is the answer. Is VA exploring that probability or any other initiatives that would improve service?

Answer: The addition of telephone circuits and an increase in dedicated staffing to telephone interview activities would work toward the resolution of identified workload management problems (abandoned and blocked call rates). Additional circuits alone would reduce blockage but increase abandoned calls. Additional staff assigned to currently available circuits would reduce abandoned calls but have little impact on blockage. As previously indicated, telephone traffic measured against the 10 percent abandonment standard is not the present problem. Nationwide, the abandoned call rate is about 8 percent. Blockage, however, is a significant problem. We are working with U.S. Sprint to identify and install, when possible, circuitry configurations that are more cost effective and, to the extent staffing is available, help overcome blockage difficulties.

Question: 32. Ed, DAV testimony for today's budget hearing cited a hypothetical case of a U.S. soldier who lost his leg during the December invasion of Panama. After receiving a discharge from the service, such a veteran would, according to the DAV, encounter various problems, under the average set of circumstances, in dealing with VA. I would like you to have the opportunity to comment on each of the four difficulties as described by the DAV.

32(A). First, the veteran tries to contact VA by telephone but is one of the 1.7 million people per year who can't get through to the Department because of busy phone lines, understaffing, or lack of budgetary support for state-of-the-art telecommunications equipment. If he is unfortunate enough to live in any of the 24 large metropolitan areas of the country which have no veterans benefits counselors serving them, he will not be able to arrange a personal visit to discuss his potential benefits.

Answer: A soldier who lost his leg during the December invasion of Panama or any similar military action would most likely have been provided VA benefits counseling and have filed an application for benefits prior to discharge from the service. Veterans Services Divisions work with military personnel responsible for pre-separation briefings to ensure that these individuals are aware of available VA benefits and have brochures and forms to provide the service members, whenever possible. In the event a service person is transferred from the military hospital to a VA hospital prior to separation, a Veterans Benefits Counselor assigned to the medical center would be available to personally meet with him as frequently as desired. Based on the current guidelines regarding contact with patients, it is probable that the VBC would have visited this patient to assist with filing a claim within the first 7 days of hospitalization in the VAMC.

Question: 32(B). Second, his may be among the 30 percent of compensation claims requiring an excess of 180 days to complete as a consequence of staffing shortages.

Answer: In the case of a serious injury or condition such as that cited in the hypothetical case, we have regulatory authority to assign a temporary pre-stabilization rating for one year based on available medical evidence. Often in these circumstances, an application for VA benefits is filed with the service department prior to or at the time of separation from service and the service department will then forward the claim, discharge certificate and service medical records to the appropriate VA regional office. We can award benefits at the earliest possible point pending receipt of necessary documentation such as additional medical records, VA examinations, etc.

Question: 32(C). Third, he files an application for vocational rehabilitation training and must wait the average response time of 100 days simply to be interviewed by a vocational counselor.

Answer: The use of the average number of days in the presented scenario may be misleading. This average response time includes those veterans who apply for vocational rehabilitation and for whom service connection must

2be established. In fact the median time for response is 78 days and 36 percent of the veterans are seen within 60 days. In the case presented, if the application is received with a copy of the discharge and related medical information, a memorandum rating would be appropriate and it is likely that the veteran would be seen within 60 days from the date of receipt in the regional office.

Question: 32(D). Fourth, months after service, his VA physician advises him that a new prosthesis is required to fit his stump but the local VA medical center does not have the funds needed to furnish in a timely manner its patients' prosthetic devices for their service-connected disability.

Answer: I do not believe that this situation would occur given the additional funding provided in FY 1990 for this program. The Veterans Health Service and Research Administration has placed a high priority on the provision of prosthetic services and is monitoring any delays.

Question: 32(E). Do these circumstances suggest that VA is failing to meet its obligations to seriously disabled service-connected veterans?

Answer: If these circumstances do occur, VA would be remiss in fulfilling its' responsibility. However, I would like to assure you that I will make every attempt to eliminate delays and improve the timeliness of the services being provided disabled service-connected veterans. These veterans certainly deserve the highest priority.

Question: 33(A). In one of the four Montgomery GI Bill regional centers -- St. Louis -- VA is experimenting with the paperless file concept of optical disk technology. This project was selected in 1988 by a national computer journal as the winner of their MIS Solution of the Year Award. Am I correct, however, that OMB denied your request for an FY 91 expansion of the optical disk initiative, for which you requested $2.4 million?

Answer: Funding for further expansion of this initiative was disapproved pending evaluation of the St. Louis experience.

Question: 33(B). How were you planning to use the requested optical disk funding in FY 91, and what impact does its denial have on the modernization of your claims processing?

Answer: The new technology would have been expanded based on the findings of the evaluation of the current prototype. The St. Louis prototype would have tested a limited aspect of optical technology. Therefore, VBA requested funding in FY 1991 to be used for an imaging prototype to test new technology more applicable to VBA processing needs. This prototype would explore methods for distributing imaging technology as well as dual capture of images and text to provide automated indexing at the time of image scanning, and to eliminate the need to manually input data. The transmission of images would also be tested along with various imaging software packages.

Lack of funds for this expansion should have little impact on the modernization of claims processing. The proposal will be reconsidered once the evaluation of the current prototype is complete. In addition, because the technology to capture the image and text is still under development in the marketplace, the additional time will allow for the refinement of this technology. This will make any potential VA investment less risky than at the current time.

Question: 33(C). In view of VBA's generally positive experience with regional processing centers in implementing the Montgomery GI Bill, are you considering consolidation of the processing of other education benefits, such as chapter 32 and chapter 35?

Answer: VBA is presently examining the issue of the consolidation of claims processing of other education benefit programs. A decision on further consolidation has not been made.

Question: 33(D)(i) (If yes) Have you given consideration to the ability of the four chapter 30 sites to handle additional consolidations and to the possible needs and locations for additional regional processing centers?

Answer: VBA is reviewing information and data pertaining to the possible consolidation of other education benefit programs. Included in the review is information concerning the four chapter 30 regional processing offices' ability to successfully handle the workload associated with a consolidation of other education benefit programs.

Question: 33(D)(ii) (If need additional sites) If, in your view, such a consolidation of education program processing at new sites would improve both the quality of service and efficiency, and would be achieved in FY 1991, would you provide the Committee by next week with itemized cost estimates (showing costs and savings) for establishing such additional regional processing centers?

Answer: A decision on further consolidation and on the need for additional regional processing sites has not been made.

Question: 34. The ADP environment seems to become more complex every year. Sometimes it becomes necessary to hire more and better-paid personnel to carry out the development and implementation of new programs. However, it appears that VA's approach is to rely on its own employees for program development.

34(A). Is it not becoming more difficult to hire and retain the type of computer technicians you need to continue making the rate of progress in modernization we all so much want?

Answer: We have found it difficult to hire personnel in the numbers necessary to support specific ADP projects that are time-sensitive.

Question: 34(B). Have you evaluated the feasibility and cost-effectiveness of contracting out the programming responsibilities?

Answer: A recent study conducted at the Austin Data Processing Center indicates that programmer support is significantly less costly when provided by VA employees than with contractor personnel. However, during peak workload periods or for time-sensitive projects, it is frequently advantageous to contract for programming support.

Contractual support has been a key element in all phases of VA's ongoing ADP modernization initiative. Since internal resources assigned to modernization in Central Office are limited, contractor support is essential in addressing the multiple, diverse and technically complex tasks comprising the modernization effort. In addition, VA has used contractor resources for its current systems, most notably in completing the technical design of specifications for new on-line functions of the insurance system.

VA has also used contractor programmer and computer systems analyst support in the development, modification and documentation of a variety of smaller applications including office automation, conversion of Insurance programs into COBOL, and planning the migration of Compensation and Pension batch programs from the Honeywell environment to the IBM migration mainframe.

34(C). [If so) Have you reached any specific conclusions?

Answer: Contractor support is essential to the completion of VA's ADP modernization initiatives and current system activities. As new initiatives are planned and identified, we consider the nature of the project and the extent to which contractor support could be effectively used. VA expects to utilize contractor support as a way to leverage its workforce and meet essential objectives within reasonable timeframes.

Question: 34(D). [If should contract more] What would be the FY 91 costs of contracting for the computer services you've identified as desirable to contract for?

Answer: Our planned obligations for information technology system (budget exhibit 43A) include contracting costs of approximately $28.5 million for ADP systems analysis, design, programming and engineering in FY 1991.

Question: 35. I was pleased to see that OMB increased the President's request for major construction by nearly 30 percent over last year. What is the reason that funding is not proposed for five of the top seven major construction projects as ranked by your prioritization?

Answer: In finalizing the VA budget submission, priorities were established based primarily on the results of the methodology and prior year initiatives by the Congress through previous design appropriations e.g. Detroit, Indianapolis and Long Beach.

The prioritization methodology does not supplant the need for executive review within the Department. This review concluded that funding would be requested to complete projects at Durham and Togus which have previous funding; for the design of seismic related improvements at Martinez; and for correction of deficiencies in surgery at Oklahoma City based on a strong recommendation of the Inspector General. In addition, it is necessary to request funding to pay the claims identified in the budget. The projects not included in the budget could not be supported within the funding level established for major construction.

Question: 36(A). Although there was a construction request increase of nearly $110 million, there was also a reduction of 30 FTE in the Office of Facilities and the dollar savings in employment closely approximated your requested increase In ADP and consultant services, plus increased travel costs for the employees who remain. Is this another example of OMB paying for ADP out of FTE?

Answer: The reduction in personal services was not used to pay for ADP increases.

Question: 36(B). Did VA propose to OMB the 30-FTE reduction?

Answer: Yes, the VA proposed the cut to OMB based upon the following improved efficiencies:

1. earlier definition of project scopes.
2. refinements in the design process (e.g. Facility Development Plans).
3. extension of design through 35% complete working drawings using Advance Planning Funds.
4. increased reliance on contract services (e.g. design and construction inspection).
5. increased reliance on automation, especially in the field.
6. fewer major projects.

Question: 37(A). What is VA's FY 90 involvement with and commitment to the National Veterans Training Institute, now being run under contract through the Department of Labor, and what VA resources will be committed in obtaining VA employee training at the NVTI and providing instructors in FY 90 and FY 91?

Answer: In 1989, 240 VA employees received training at the National Veterans' Employment and Training Services Institute (NVTI) including 120 of the 439 counseling psychologists and vocational rehabilitation specialists. Three FTEE in FY 1990 are committed to the NVTI as resource personnel and instructional staff. It is anticipated that similar support will be provided in FY 1991.

Question: 37(B). Under section 402 of Public Law 100-689, VA and DOL were required to enter into a memorandum of understanding to carry out the purpose of that section, which is to ensure that veterans who are dislocated workers eligible for assistance under title III of the Job Training Partnership Act or who are otherwise unemployed receive vocational assistance, including vocational guidance or counseling. What VA and what DOL resources in FY 90 and FY 91 will be committed to joint VA/DOL efforts to ensure that such veterans are informed of and have access to all employment and training services for which they are eligible?

Answer: The DVA and DOL have concluded a national agreement, and thirty State-DVA local agreements have been completed. It is anticipated that the remainder will be completed in the near future. These agreements provide a foundation of cooperation that will ensure notification to veterans of availability for vocational guidance and counseling. All veterans who are otherwise entitled to VA educational benefits will receive vocational and educational guidance from the DVA. Extensive use of contract counseling centers is planned to meet this need. The number of contract guidance centers have been increased from 9 to 51 in the last 6 months and efforts are continuing to expand this resource.

Question: 38. D'Wayne Gray, the Chief Benefits Director-designate, in response to his pre-confirmation hearing question 17 regarding the performance of the four Montgomery GI Bill regional centers in implementing the MGIB, said he was advised that the four centers were doing a very capable job of processing chapter 30 claims and that "(a)ll four offices are handling the workload in an adequate and timely manner." Earlier this week, on February 20, State Approving Agency representatives meeting here in Washington said that there are large backlogs of chapter 30 claims in the four centers and that school certifying officials, a position subject to a high turnover rate, often do not know where to send the forms.

Needless to say, this news was distressing, especially in light of DOD's projected increase in MGIB usage, and the possible impact of a large military troop reduction on utilization of education benefits. I think this information raises sufficient questions about the wisdom of the consolidation as to require an independent look at the situation at the four sites. Could you initiate an IG audit of this matter right away?

Answer: During the first quarter of FY 1990, the processing of chapter 30 original and supplemental claims by the four regional processing offices (RPOs) met the established timeliness standards. During January and February 1990 the workload at the four RPOs has increased as a result of the chapter 34/30 conversion and second term reenrollments. (The conversion process added between 30,000 and 35,000 cases to the RPOs' workload.) The situation is being closely monitored, and it is expected that this large, one-time workload at the four RPOs will be processed and action on the claims will be completed in the near future. In anticipation of the return of the chapter 30 workload at the four RPOs to a normal, seasonal level, we believe it would be premature to request an IG review/audit of the regionalized processing of chapter 30 claims at this time.

Concerning the perceived problem with new certifying officials, The American Association of Collegiate Registrars and Admissions Officers (AACRAO) publishes in cooperation with VA and DoD, a certification manual titled "Certification of Students Under Veterans' Laws." This manual is provided to all certifying officials and other advisors of beneficiaries of VA education programs. The manual was revised on 9/1/89 to provide complete information on the regionalized processing of chapter 30 claims, the geographical responsibility of the four RPOs, and the appropriate office where chapter 30 claims are to be sent and where questions about chapter 30 claims are to be directed. This revision was sent to all certifying officials and veteran advisors. If the Committee is aware of specific schools or specific states in which, according to State Approving Agency representatives, certifying officials need additional assistance or guidance on chapter 30 processing procedures, we would welcome having such information so we can follow-up with them and then report back to you.

Question: 39. Attached is a copy of a February 6, 1990 letter from Senator Murkowski and me to OMB Director Richard Darman urging his approval of a Department request for the submission of legislation to exempt from the requirements of the Computer Matching Privacy Protection Act certain VA/Department of Defense computer operations involved in the administration of certain educational benefits. Would you please inquire with Mr. Darman as to the status of the proposed legislation and his response to our letter and convey to him my interest in prompt submission of the measure?

Answer: The Department of Veterans Affairs (VA), Office of General Counsel, has been asked to prepare a legislative package for submission to the Office of Management and Budget (OMB) which would exempt chapter 30, 32, and 106 education benefits programs computer matches with the Department of Defense from the coverage of the Computer Matching and Privacy Protection Act of 1988. The legislative initiative has been drafted and is in final concurrence process within VA and will be submitted to OMB in the near future. VA will monitor the status of the legislative proposal to ensure that OMB continues to be aware of the Committee's and our interest in this matter.

Question: 40. I have asked several prehearing questions about the National Cemetery System's equipment backlog, and I expect that those answers will give us a detailed basis for evaluating both the equipment needs and the long-term cost effects of the backlog. However, would you please describe your current plans to deal with this backlog problem under the funding levels for this year and those contained in the FY 1991 budget submission?

Answer: In the current budgetary environment and within the funding levels for 1990, resources to address the problem are limited. In FY 1991, $2.2 million is requested for replacement equipment. These resources will primarily fund the most critical equipment due for replacement. Equipment is replaced within available funding and in priority of need. All other equipment is maintained as well as practicable.

It is estimated that the backlog of equipment in need of replacement will total $6.4 million by the end of 1990. Although the level of funding requested for 1991 is significant, the backlog will actually increase by $300 thousand as measured by the VA's LOG I System.

The National Cemetery System is continually evaluating the equipment situation and is doing everything that can be managerially done to maintain its operations and service.

Question: 41. A review of the Medical and Prosthetics Research Account budget makes it apparent that, due to the cut in VA-provided funding, the research budget relies on increases in non-VA-designated research support to maintain an even keel. I am concerned, however -- even after receiving an answer to my prehearing question on this topic -- that the assumptions VA made in calculating expected funding from NIH grants and direct or indirect in-kind contributions through the medical care appropriation may not be correct.

41(a). Please give examples of both direct and indirect support -- as research from general medical care funding.

Answer: Except for the physicians in the Medical Research Career Development Program (approximately 220), the salaries for clinicians are paid by medical care. An example of direct support is the funding of the clinician's time, supported by medical care, devoted to research. On an average this would amount to 20-25 percent.

An example of indirect support would be the time supply, personnel, engineering and other administrative service are involved with research activities.

Question: 41(b)(1). Does VA assume, as the basis for the estimates of research support from the medical care account, that a given increase in medical care appropriation dollars would provide a certain proportionate increase in research support?

Answer: Yes

Question: 41(b)(2). If so, what is the factor?

Answer: Medical Care funding increased by eight percent in 1991 over 1990, and the eight percent increase was applied to the research support from Medical Care.

Question: 41(c). Please provide information on NIH funding to VA-based research for each of FYs 1980-1989 in the following areas:

(i) Numbers of new projects funded each year;
(ii) numbers of projects active each year; and
(iii) dollar amount (and FTE covered) of NIH funding to VA-based researchers each year. Please note for clarity whether NIH grants and contracts went to researchers through VA or through affiliate auspices (e.g., which institutions received the overhead and support staff).

Answer: The information available concerning other federal grants is grants to VA staff for which the research is conducted at the VA and/or the university. Information on NIH funding to only VA-based research is not collected.

FY	New Projects	Number of Active Projects	Funding* Other Federal Sources	FTEE** (est)
1984	Not Available	1,021	48,820,130	
1985	"	1,057	58,578,477	
1986	"	1,060	70,493,075	
VA	"		(3,513,881)	65
Univ	"		(66,979,194)	
1987	"	1,098	81,227,202	
VA	"		4,290,562	80
Univ	"		76,936,640	
1988	"	1,150	93,091,004	
VA	"		4,606,180	80
Univ	"		89,484,824	
1989	"	1,145	105,149,669	
VA	"		5,809,102	100
Univ	"		99,340,567	

* Until 1989 information on Federal support to VA research was not identified by Federal Agency source. For FY 1984-1985 total federal funding is identified. In FY 1986-1989, both University and VA administered funding are identified.

** As noted in the funding columns, approximately 95% of the grants are administered by affiliated universities. As such, no VA FTE are required and university personnel associated with the university administered grants are not reported to VA. The FTE estimate is based on the funding directly administered to VA.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

APR 18 1990

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are the remaining responses to the post-hearing questions you submitted in your letter of March 8, 1990.

Please let me know if we can be of further assistance.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosures

EJD/map

SENATOR CRANSTON

Question: 42. VA's response to budget-hearing question 57(B) states that it is currently studying the Security and Law Enforcement program to determine the appropriate staffing levels for Central Office and regional oversight activity. VA's December 22, 1989, response to the Committee on security force matters had said that the service staffing will be reviewed within 120 days following the appointment of the new director, which occurred on October 8, 1989. Approximately, 140 days have now elapsed since the appointment and, yet the review of Service staffing has apparently not yet been completed. What is the reason for the delay and when is the review of service staffing now expected to be completed?

Answer: We have now determined that approximately thirteen additional FTEE will be necessary to accomplish the expanded mission of the Office of Security and Law Enforcement. The establishment of this office and its alignment under the Assistant Secretary for Human Resources & Administration came relatively late in the 1991 budget cycle. Therefore, efforts are currently underway to identify the sources of funding required in order to support these additional positions in 1991. The resources needed to carry out the expanded mission of the Office of Security and Law Enforcement will be fully addressed from the start of the Department's 1992 budget formulation process.

Question: 43. VA's response to prehearing question 58(A) states that it is currently studying the Security and Law Enforcement program to determine the amount of staffing necessary to conduct Central Office program evaluations of the Security Service at each VAMC every two years. What is the status of that study and when will it be completed?

Answer: We have now determined that four additional Regional Security Officers will be necessary in order to complete program inspections every two years. Currently, VA has four Regional Security Officers on duty. The additional four FTEE are included among the thirteen positions mentioned in response to Question 42.

Question: 44. VA's response to pre-hearing question 78(A) indicated that it has not assessed the size and needs of the prosthetics target population in order to develop a budget forecasting model. A February 1988 report prepared by the Office of Program Planning and Evaluation's Management and Organization Service, entitled "Prosthetic and Sensory Aids Service Field Operations Study," recommended that Central Office Prosthetic and Sensory Aids Service (PSAS) request that the Office of Information Management and Statistics undertake such as assessment.

Question: 44(A) Has such a request been made?

Answer: There are many reasons why such a request was not made. The development of budgets at VA medical centers is heavily based on actual cost and usage. Current methods for developing budgets do account for both the size and needs of the veteran population. A forecasting model based solely on an expected target population would not produce accurate projections of actual veterans seeking service from VA medical facilities. We would point out that the referenced report contained only one instance of insufficient budget planning at the facilities studied.

Question: 44(B)(i) If not, why not?

Answer: See response to Question 44(A) above.

Question: 44(B)(ii) If yes, did the Office of Information Management and Statistics undertake the assessment and , if not, why not; if yes, what were the results.

Answer: Not applicable.

Question: 45. VA's response to pre-hearing question 80(A) states that there has been no funding shortfall for prosthetics in the last five years. According to information available to the Committee derived from VA White Papers and other VA sources, there have been prosthetics funding shortfalls in each of the FYs 1987, 1988, and 1989. Specifically, for each of these years, this information indicated that there was a funding shortfall of $3,455,377, $5,216,631, and $10,600,000, respectively, and that prosthetics orders held (or backlogged) amounted to 5,188, 7,552, and 3,161 orders, respectively.

Question: 45(A) Please reconcile VA's answer to this question with the information just presented and explain the reason for the differences.

Answer: The responses provided to question 80(A) recognize that overall Medical Care funding was deemed adequate in FYs 1987-89. The information cited was an estimated shortfall based on information provided to the Prosthetic Task Force by VA medical center directors in response to a survey undertaken in the first quarter of FY 1989. While the results of such surveys are a good snapshot of operations at a particular point in time, overall medical care funding shortfalls should not be inferred. The 3,161 orders referenced as delayed in FY 1989 amounted to $5,630,000 in the fourth quarter. The additional $5 million provided the Prosthetic Program by the FY 1989 supplemental effectively eliminated the backlog.

Question: 45(B)(i) Has VA made changes in its budget forecasting for prosthetics in order to preclude shortfalls from occurring in FY 1990 and 1991?

Answer: The VA has not changed its budget forecasting methodology for prosthetics supplies and services. The VA has provided management guidance and is monitoring the provision of prosthetics services to assure appropriate services are provided. The funding provided for FY 1990 and that requested for FY 1991 should be sufficient to permit prompt provision of prosthetic services.

Question: 45(B)(ii) If so, what are the changes?

Answer: Not applicable.

Question: 46. VA's response to pre-hearing question 80(B) states that no prosthetic funding shortfall is expected to occur in FY 1990? However, according to the VA Chief Medical Director's testimony at the Committee's February 23, 1990 budget hearing, there were 1,000 backlogs in prosthetic orders for January 1990. How specifically does VA plan to reduce the present (i.e., January 1990) backlog before the end of the fiscal year?

Answer: The response to the pre-hearing question was correct. The delayed orders cited by the Chief Medical Director were not the result of funding differences and appear to be primarily caused by temporary staffing shortages because of unexpected turnover or absences, e.g., sickness, early retirement, annual leave, etc. The Regional Directors are monitoring all delayed orders and have requested specific action plans to eliminate delays at those facilities where they are occurring.

Question: 47. VA's response to pre-hearing question 80(C) states that it has provided guidance to the field establishing a priority for procurement of prosthetic items as a means of precluding prosthetics backlogs in FYs 1990 and 1991. According to the November 15, 1988, VA Prosthetics Task Force Report, additional funding and FTE were needed at that time to reduce the prosthetics backlog. Please reconcile the VA answer with this VA report and explain how priority procurement of prosthetics items can preclude a backlog if funding and FTE are insufficient.

Answer: One of the actions determined to be needed subsequent to the Prosthetics Task Force Report was assigning a higher priority to funding prosthetics services and monitoring to assure timely provision of services. Managerial oversight in this area has received, and will continue to receive, focused attention from the Secretary on down the line. Separate and apart from those actions we have stated that sufficient funds are available in FY 1990 and requested for FY 1991 for prosthetics services.

Question: 48. VA's response to prehearing question 82.A. states that operating plans for the MAMOE account for FY 1991 have not been developed at this point in time; therefore, VA does not know the level of VACO site visits that will be funded in FY 1991.

Question: 48(a). What are your views on implementing a plan in which PSAS at VACO would site visit all 172 VAMCs on a 5-year cycle?

Answer: A management efficiency survey of the VACO Prosthetic Service is currently being conducted by a team headed by Mr. Sid Ford, Regional Director of the Midwestern Region. This team is reviewing the staffing, capabilities, resources and other factors affecting the mission of the Prosthetic and Sensory Aids Service. After we have had the opportunity to review the findings of the management efficiency team, we will be able to better respond to this proposal.

Question: 48(b). What would be the annual funding and FTE cost associated with implementing such a plan?

Answer: As stated above, we would like to address this issue when the review team completes its task.

Question: 49. VA's response to prehearing question 83(D) states that the 8 orthotics laboratories identified by VA in response to question 83(C) may be funded if they are consistent with the Secretary's priorities for veterans' health care and are determined to be cost-effective.

Question: 49(a). Isn't the question of their cost effectiveness already determined since, according to VA's response to question 83(B), cost-effectiveness is the main criterion for identification and justification of an orthotics laboratory?

Answer: Yes, it has been determined, based on cost-effectiveness, that it would be advantageous to establish eight additional orthotic laboratories at these facilities cited. However, VA has many priorities which are cost effective and/or improve services and they cannot all be funded.

Question: 49(b). If not, on what basis were these 8 potential sites for orthotics laboratories identified?

Answer: As stated above, VA will continue to strive to make the best choices of modalities of care for the widest group of veterans in need of care.

Question: 50. VA's response to prehearing question 83(F) states that the amounts expended for braces in normal years do not clearly indicate that the establishment of an orthotics laboratory at the Washington, D.C. VAMC would be cost-effective.

Question: 50(A). What would be the cost (for FTE and a basic laboratory) to establish an orthotics laboratory at this VAMC?

Answer: Approximately $85,000 based upon hiring a GS-10/1 Orthotist, 22% fringe benefits and $50,000 for equipment, supplies and minor renovation. If major renovation is required, the costs would be considerably higher. This estimate does not include operating costs for material which must be replaced as it is used.

Question: 50(B). Please conduct (and provide the results of) a cost-benefit analysis of having an orthotics laboratory at this VAMC.

Answer: Available data on commercial costs RCS 10-0001, FYs 1987, 1988, and 1989.

	FY 1987	FY 1988	FY 1989	3 Yr Average
Braces	$ 60,593	$ 85,625	$ 45,355	$ 63,858
Corsets/Belts	2,811	13,960	13,761	10,177
Elastic Hose	7,385	17,174	14,057	12,872
Total	$ 70,789	$116,759	$ 73,173	$ 86,907

Given the above data, the average amount expended for orthotic devices from commercial sources is $86,907. This amount is not a cost saving since the orthotic devices still must be provided. What would be saved is based on the average mark-up of 124% used in the prosthetic/orthotic industry.

Potential Cost Savings 3 Yr. Average

$86,907 - $38,800 = $48,107

Projected Costs for Establishment of Orthotic Laboratory

GS-10/1, Orthotist	$ 27,200
Fringe Benefits	1,984
Initial Equipment, Supplies, Minor Restoration	50,000
Operating Supplies, e.g., components, orthotic software, etc.	38,800
Total	$121,984

Annual Operating Costs (2nd Year)

Salary/Fringe Benefits + 3.5%	$ 34,345
Operating Supplies + 7%	41,516
Total	$ 75,861

Net Loss First Year

$121,984 - $35,077 = $86,907

Net Gain Second Year

$75,861 - $92,990 (86,907 + 7%) = $17,129

Question: 51. Based on the current response time of the BVA, how many additional FTE would be needed in FY 1991 to allow the BVA to meet a 135-day timeliness response standard?

Answer: At the productivity level used to project the BVA program highlights in the President's budget, it would require an estimated additional 33 FTE, or a total of 455 FTE, to reduce BVA response time to 135 days by the conclusion of FY 1991. However, we are looking at other ways to reduce response time by increasing productivity using current resources, including increased use of office automation by placing workstations at the disposal of each of our BVA staff attorneys and Board

Question: 52. During last year's budget hearing, Secretary Derwinski stated that he had advised the Chief Medical Director that, until further notice, decisions regarding the closure or reduction of substance abuse programs will no longer be at the discretion of the individual medical centers and would have to be approved by him. Is this policy still in effect?

Answer: Yes, this policy is still in effect.

Question: 53. According to information provided by the National Institute of Drug Abuse (NIDA) and the National Institute of Alcohol Abuse (NIAA), it appears that California residents comprise 14 percent of the nationwide illicit drug users and 23 percent of those with alcohol problems. Assuming that similar percentages of drug and alcohol abusers in California exist among the veteran population--and I know of no reason to assume otherwise--I am concerned that only 6.7 percent of the FY 1990 $60 million Congressional add-on for VA substance-abuse treatment programs has thus far been allocated to California VA facilities. In view of California's very large proportionate share of the Nation's substance abuse problem, I believe that a higher percentage of the $60 million needs to be allocated to California VA facilities and programs. Would you please look into this and see if steps can be taken to provide a more equitable allocation of the total $60 million substance-abuse Congressional add-on by directing an appropriate distribution to California facilities from the unallocated funds?

Answer: The substance abuse Congressional add-on is being distributed to medical centers based on needs identified by each medical center. All of the 12 California medical centers submitting proposals were funded at essentially the levels they requested.

There are remaining resources yet to be distributed. California medical centers will be receiving laboratory and pharmacy support and support for ADP equipment. In addition, VAMC Palo Alto will be participating in the Compensated Work Therapy/Independent Living Housing pilot program and will be provided additional resources for this program in the near future.

Question: 54. The Committee has heard, both informally and from witnesses at the Committee's February 23 hearing and at earlier hearings, that placements by VA in community nursing homes are becoming less frequent and shorter in length. In this regard, please provide for each of FYs 1985 through 1990, the following:

54(A). The number of VA inpatient episodes that have ended with a discharge to a community nursing home on a VA contract, broken down, if possible, by type of VA bed of origination (acute care, intermediate care, nursing home care, domiciliary, or other).

Answer: Complete information on medical center versus direct community placements and on bed section of origin for patients placed in the Community Nursing Home Program (CNH) is not available. The available information does indicate approximately five percent of all placements are direct placements from non-VA settings. The chart below shows the number of veterans placed in contract nursing homes in FY 1985 - FY 1990.

YEAR	PLACEMENTS
1985	28,487
1986	29,753
1987	29,986
1988	29,350
1989	20,606
1990	20,156*

*Estimate.

Question: 54(B). The total number of days VA patients were placed in VA-contract community nursing homes.

Answer: The chart below shows the number of patient days in the CNH Program for FY 1985 - FY 1990.

YEAR	PATIENT DAYS
1985	4,177,060
1986	4,389,490
1987	4,471,615
1988	4,540,230
1989	3,396,325
1990	3,322,230*

*Estimate.

Question: 54(C). The average length of stay of VA patients in VA-contract community nursing homes, broken down, if possible, by medical region.

Answer: The chart below lists the average length of stay for CNH patients by region for FY 1985 - FY 1989. FY 1990 data is not available. The current configuration of the regions is used for all fiscal years.

REGION	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989
ONE	214.3	198.5	205.6	192.0	209.2
TWO	179.1	177.0	170.5	167.2	164.4
THREE	140.7	136.9	136.9	135.3	123.3
FOUR	173.5	163.4	168.8	169.1	169.7
FIVE	129.5	130.6	128.0	120.9	116.4
SIX	140.0	145.4	148.8	136.4	134.6
SEVEN	124.8	121.0	124.8	119.7	120.1

Question: 54(D). The dollar amounts -- both originally projected when the appropriation was made each year and ultimately expended that year -- attributed to community nursing home care.

Answer: The chart below lists the funds identified for the CNH Program at the time of the appropriation and the actual expenditures for CNH care for FY 1985 - FY 1990.

YEAR	APPROPRIATION ($000)	EXPENDITURES ($000)
1985	$253,146	$250,094
1986	278,446	281,482
1987	305,021	301,483
1988	325,833	321,578
1989	352,387	250,951
1990	309,316	not available

Question: 54(E). The per diem rate paid for community nursing home care, system-wide or, if appropriate, by region along with number of days per region so that a system-wide weighted average could be calculated.

Answer: The national average CNH per diem rate was: $59.87 in FY 1985; $64.13 in FY 1986; $67.42 in FY 1987; $70.83 in FY 1988; and $73.89 in FY 1989. The estimated per diem rate for FY 1990 is $77.96.

Question: 54(F). For items B, C, and D, above, please respond separately as to patients who are admitted to VA-contract community nursing homes directly from their own homes or from a non-VA facility.

Answer: Complete information on patients placed into the CNH Program from non-VA settings is not available. The available information does indicate approximately five percent of all placements are direct placements from non-VA settings.

SENATOR CRANSTON

ADP SYSTEMS MANAGEMENT

Question: 1. Please provide us a list of ADP initiatives which VBA requested in 1991 but which OMB denied.

Answer: Following is a list of ADP initiatives requested by VBA in the 1991 OMB submission that were denied in the OMB passback:

Initiative	Amount ($000s)
Long-Term Solution	$ 1,500
Loan Production System	6,424
Int. Target/OA Access-Itinerant	1,930
Optical Disk	2,400
On-Line Help System (Education)	450
Chapter 106	675
Veterans Assistance Quality Mgmt.	694
Remittance Processing	1,100
Insurance Technology Upgrade	4,677
Additional FTEE for Insurance/CO	16 FTEE
Two-Year Funding Authority	...

ADP SYSTEMS MANAGEMENT

Question: 2. Please provide short-term initiative savings by project and year.

Answer: See attachment.

DEPARTMENT OF VETERANS BENEFITS
1991 PRESIDENT'S BUDGET
MODERNIZATION SAVINGS

(1987 through 1995) (1987 through 1995)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation					327	*	327
Automate Payment History File	8					57	65
Fiduciary & Field Exam. Automation (F&FE)	32						32
File Maintenance Operations							
Loan Guaranty Automated Payment File						51	51
Local Access To CAROL/CALM History (LATCH)					20	19	39
Voucher Integration and Payment System (VIPS)						61	61
Veterans Records (Bar-Coding)		281					281
Target-Itinerant							
Target-Outbased	19						19
Target-Central Office	19	19			139	3	180
VBA/VHS&RA Data Exchange							
LPS			92		70	50	212
TOTAL	78	300	92	—	556	241	1,267

(1987) (1987)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation					264		264
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)							
Target-Itinerant							
Target-Outbased							
Target-Central Office							
VBA/VHS&RA Data Exchange							
LPS							
TOTAL					264		264

(1988) (1988)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation					63		63
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)							
Target-Itinerant							
Target-Outbased							
Target-Central Office							
VBA/VHS&RA Data Exchange							
LPS							
TOTAL					63		63

(1989) (1989)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File	8					57	65
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)					20		20
Voucher Integration and Payment System (VIPS)						15	15
Veterans Records (Bar-Coding)							
Target-Itinerant							
Target-Outbased							
Target-Central Office							
VBA/VHS&RA Data Exchange							
LPS							
TOTAL	8	—	—	—	20	72	100

(1990) (1990)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)	16						16
File Maintenance Operations							
Loan Guaranty Automated Payment File						21	21
Local Access To CAROL/CALM History (LATCH)						19	19
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)							
Target-Itinerant							
Target-Outbased							
Target-Central Office							
VBA/VHS&RA Data Exchange							
LPS			42		39	34	115
TOTAL	16	—	42	—	39	74	171

(1991) (1991)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)	16						16
File Maintenance Operations							
Loan Guaranty Automated Payment File						30	30
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)						46	46
Veterans Records (Bar-Coding)		18					18
Target-Itinerant							
Target-Outbased	19						19
Target-Central Office	6	8			16		30
VBA/VHS&RA Data Exchange							
LPS			31	—	27	16	74
TOTAL	41	26	31		43	92	233

(1992) (1992)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)		68					68
Target-Itinerant							
Target-Outbased							
Target-Central Office	6	11			17		34
VBA/VHS&RA Data Exchange							
LPS			11	—	4	—	15
TOTAL	6	79	11		21		117

(1993) (1993)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)		67					67
Target-Itinerant							
Target-Outbased							
Target-Central Office	7				106	3	116
VBA/VHS&RA Data Exchange							
LPS			8				8
TOTAL	7	67	8		106	3	191

(1994) (1994)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)		65					65
Target-Itinerant							
Target-Outbased							
Target-Central Office							
VBA/VHS&RA Data Exchange							
LPS							
TOTAL		65					65

(1995) (1995)

COST-BENEFIT ANALYSIS	VETERANS SERVICES	CP&E	LOAN GUARANTY	VR&C	ADMIN	FINANCE	Total
Office Automation							
Automate Payment History File							
Fiduciary & Field Exam. Automation (F&FE)							
File Maintenance Operations							
Loan Guaranty Automated Payment File							
Local Access To CAROL/CALM History (LATCH)							
Voucher Integration and Payment System (VIPS)							
Veterans Records (Bar-Coding)		63					63
Target-Itinerant							
Target-Outbased							
Target-Central Office							
VBA/VHS&RA Data Exchange							
LPS							
TOTAL		63					63

VETERANS SERVICES

Question: 3. Status Report of ACDs

- Number of sites completed
- Number scheduled for 1990 and 1991
- Number scheduled for beyond 1991

Answer: Fifty automatic call distributors (ACDs) and seven automatic call sequencers (ACSs) are installed among 57 VBA field stations. All ACDs and six of the seven ACSs are equipped with associated management information systems. Call-handling equipment is not installed at the Manila RO.

In FY 1988, VBA purchased ACDs with enhanced management information capabilities for 12 field stations. In FY 1989, we procured ACDs with associated management information systems for two additional stations. If funds become available in FY 1990, we will replace the ACSs installed at five field stations with ACDS. Beginning with the formulation of the FY 1991 budget, stations were asked to project their anticipated telephone technology needs. These costs are to be included in their advanced procurement plans and in their individual station budgets. Future emphasis will be on maintenance and replacement of equipment. The technological life of call-handling equipment is approximately five years.

Question: 4: What are the blocked and lost call percentages for 1989, 1990, and 1991? Please provide your formula for calculating lost call percentages.

Answer: The VA's call-handling equipment cannot measure blockage. Annually, local telephone companies are requested to conduct a study of blockage and usage for each line group. The FY 1989 annual traffic studies are being analyzed currently. We expect to complete this analysis shortly and will be able to determine the percentage of calls blocked.

The percentage of blocked calls for FY 1990 and FY 1991 cannot be projected. Data from the prior year telephone traffic studies disclosed that nearly every regional office exceeds the allowable 10 percent (B.10) blockage standard. (The 10 percent standard was established based on industry standards derived from historical data.) The problems of procured circuitry vs. available staff are intertwined. Limited staffing resources drive both national and local organizations to reduce available circuitry to prevent high levels of abandoned calls. The result is high blockage as long as public demand remains high.

The electronic management information systems register the number of callers reaching the VA and the number of callers who hang up before talking to a veterans benefits counselor. The percentage of abandoned calls is calculated by dividing the number of calls received by the number of calls abandoned. It is expected that the abandoned call percentages for FY 1990 and FY 1991 will remain within the 10 percent standard.

STATISTICAL DATA	FY 1988	FY 1989
Calls received	9,422,204	9,013,477
Calls abandoned	748,621	674,368
Percent abandoned	7.9	7.5
Calls blocked	2,207,264	Pending
Not receiving telephone service	623,464	Pending
Blockage		
Local	19.1%	Pending
800-service	33.4%	Pending
FX	31.8%	Pending

Question: 5. Please provide the number of VBCs outbased by category, e.g., Vet Centers, Hospitals, Employment Service Offices, Clinics.

Answer: It is becoming less common for outbased employees to spend 100 percent of their time at a single facility. Duty stations that were once staffed by outbased employees are more frequently staffed on a part time basis by regional office employees, employees who travel among two or more outbased locations, or employees whose primary duties include field examinations or compliance surveys.

In addition to the categories mentioned in the question, counselors are routinely scheduled to provide services at varying outbased locations on an itinerant basis. The selected locations are staffed on a basis of anywhere from five days each week to one day every other month, depending on the demand for service and the availability of staffing. Examples of this type of location include state veterans homes, military bases, and cities without other VA facilities.

The numbers provided below provide a summary of time spent by regularly assigned employees at the outbased category specified.

CATEGORY	FTEE
VA Medical Centers (VAMC)	132.6
VA Outpatient Clinics (VAOPC)	15.8
Veterans Assistance Offices (VAO)	24.8
Vet Centers	1.3
Employment Service Offices	0.0
Itinerant Locations	17.1

LOAN GUARANTY

Question: 6. Please provide a list of the 88 FTEE distributed to the field by station and explain the methodology used to determine the distribution.

Answer: A copy of our recommended allocation of the 88 FTEE for Loan Service and Claims is as follows:

Columbia	1	Roanoke	3
Denver	6	St. Petersburg	11
Houston	16	Waco	18
Muskogee	4	Winston-Salem	2
Nashville	2	Albuquerque	1
New Orleans	3	San Francisco	8
Phoenix	9	Atlanta	4

In determining the distribution, we added GI loan defaults pending to the active vendee loan portfolio for each station and divided the sum by an estimate of the number of Loan Service Representatives to obtain a servicing caseload per technician. (The number of Loan Service Representatives was estimated as 38% of the total Loan Service and Claims Section staffing.) The 88 FTEE were generally distributed in accordance with the size of the caseload with certain adjustments:

a. Allocation of the FTEE was concentrated in field stations with more than five Loan Service Representatives on the assumption that larger offices can establish a more efficient servicing unit.

b. Field stations with exceptionally high workload were given special consideration, as were stations which were experiencing an increase in defaults.

c. For the stations selected, allocation was generally based on the size of the caseload per Loan Service Representative.

Question: 7. What is the marginal return for adding each FTEE? Is there a point where additional FTEE provide a diminishing return?

Answer: There is no methodology in place for projecting marginal return for each additional FTEE. During the course of our pilot servicing project in Houston, 415 loans were identified as being cured specifically due to direct VA intervention with the lender. This amounted to 21 cures per Loan Service Representative assigned to GI loan servicing. A rough loss estimate of $20,000 per loan foreclosure indicates the average return per GI loan servicing FTEE was $420,000. It should be noted that, in addition to working out reinstatements, further benefits are obtained by these staff through development of alternatives to foreclosure; e.g., during the pilot project our Houston office helped 144 veterans avoid foreclosure through refunding.

We are unable to project the point at which additional servicing FTEE would be unproductive. We do, however, monitor performance and productivity at each field station and staffing level adjustments can be made if it appears that a Loan Service and Claims Section cannot make effective use of its authorized personnel.

Question: 8. Please explain the methodology used to develop the 1991 request of $512.2 million in the Loan Guaranty Revolving Fund.

Answer: The $512.2 million appropriation request was developed by using the Loan Guaranty Budget Model which develops loan originations and applies a nine year experience of foreclosure rates. The originations and foreclosures are developed for nine census divisions to take into account regional differences in economic conditions. The model further develops the number of claim payments based upon macro-economic variables such as interest rates, inflation rates, total population, housing starts, regional unemployment rates, etc. The macro-economic variables were based upon Wharton Econometric Forecasting Associates (WEFA) tables that provide a breakdown on a national and census division level. Based upon the number of claim payments, it was assumed VA would have an 83 percent property acquisition rate. The amount of vendee loan sales were based upon selling approximately 64 percent of current year vendees established and 21 percent of the prior year production. It was also assumed VA would sell 77 percent of total properties on hand to reduce the inventory to a level below 10,000 properties. Of the total number of properties sold, it was assumed 50 percent would be sold for cash and 50 percent on terms. Generally, a five percent average increase in program costs was applied to the workload items to develop total obligations.

Question: 9. Please explain the methodology used to calculate the need for an appropriation request to fund the Guaranty and Indemnity Fund in 1995.

Answer: The methodology used to develop the estimates were predicted on the Loan Guaranty Revolving Fund's five year plan for home loan originations plus an adjustment for increased entitlement loans. Total costs to the Guaranty and Indemnity Fund are driven by the rate of foreclosure of guaranteed loans.

VA used a termination rate of 6.47 percent for the first five years and 10.39 percent cumulative for ten years. This termination rate is higher than the program experienced in the 1970's but lower than the foreclosure frequency of the 1980's.

For FY 1995 estimates it was assumed that the property acquisition rate would be 85 percent of home loan claims. Of the total properties in the inventory, it was assumed that 57 percent would be sold in 1995. Of these, 50 percent would be sold on terms and 50 percent would be sold for cash.

Vendee loan sales, starting in 1993 and continuing through 1995, were calculated using the assumption that 85 percent of vendees established will be sold annually, of which 64 percent are from current year production and 21 percent are from prior year establishments.

An appropriation is estimated to be needed in 1995, but as early as 1992 obligations are expected to increase to a level greater than offsetting collections, thus requiring the use of invested funds. The funds accrue primarily from the collection of the funding fee (ranging from .50 to 1.25 percent) based upon the type of loan and the loan amount as well as from the .25 percent Government contribution based upon the loan amount. By 1995, obligations ($1,333.5 million) are expected to be $421.7 million greater than the revenue from offsetting collections ($911.8 million). As a result, a $218.4 million appropriation is expected to be needed to fully fund program costs, and to allow for a $25 million unobligated balance at the beginning of FY 1996.

Question: 10. Does your budget for the new Guaranty and Indemnity Fund calculate the government contribution based on PL 101-237, as written, or is it based on the intent of PL 101-237?

Answer: Public Law 101-237 has a technical error which provides, under section 1829(a)(3), that the government contribution on loans having a 10 percent or more downpayment will be 1.25 percent (.25 percent for three years, under section 1825(c)(2)(A) or (B) plus .25 percent for two years under section 1829(a)(3). The budget estimates are based on the intent of the law which would require a government contribution of .5 percent over two years on loans having a 10 percent or more downpayment.

Question: 11. After the consolidation of Loan Guaranty activities in New England, the Manchester Regional Office will devote one FTEE to the Specially Adapted Housing activity. Please explain how this one FTEE will service the activity throughout New England without negatively impacting the efficiency of service.

Answer: Presently, Specially Adapted Housing (SAH) actions are processed in all four offices by employees who perform varied duties. No one is assigned SAH processing as his/her primary duty. Two offices (Boston and Hartford) have centralized authority to approve SAH grants without VA Central Office authority. Manchester and Togus must submit SAH cases to VA Central Office for approval prior to issuing a grant. In the consolidated office, there will be a Specially Adapted Housing Agent whose primary responsibility will be processing SAH applications and who will have centralized authority to approve grants. This should expedite service to disabled veterans seeking specially adapted housing in the New England area.

Question: 12. Does VBA plan to expand the Houston Pilot Project?

Answer: The purpose of the Houston Pilot Project was to evaluate the theory that improved Loan Service and Claims staffing, combined with adequate equipment and use of an irregular tour of duty, would increase both cured defaults and use of alternatives to foreclosure. We believe the project was successful in this regard and other field stations will be advised of this fact. All field stations, with a special emphasis on those receiving additional servicing FTEE, will be monitored for servicing improvement.

COMPENSATION, PENSION AND EDUCATION

Question: 13. Please provide a white paper discussing the reconciliation of VBA's pending workload estimate with the estimate used by the Paralyzed Veterans of America.

Answer: During the 1991 budget formulation process, VBA's initial analysis of current resource levels and anticipated workloads showed that, if staffing was not increased in the Compensation, Pension and Education (CP&E) Program, pending work would increase to over 700,000 cases.

Service organizations have apparently used some of these theoretical pending workload figures in developing their own budget. However, the pending workload we estimated during the 1991 budget formulation process has not materialized. CP&E staffing has increased steadily over the last five months (instead of decreasing), so pending workload has stabilized and even started to improve.

The pending workload is defined as the number of claims or issues on which final action has not been completed. It is measured from our Work-In-Progress (WIPP) system which tracks all claims that are in a pending status. Processing instructions require that all claims be entered into the WIPP system until they are finally adjudicated. The WIPP system can therefore provide an accurate and detailed report of all claims pending in the VBA system.

At the end of FY 1988 and FY 1989, WIPP data showed the following pending backlogs:

	1988	1989
Compensation and Pension	368,927	343,199
Education	51,043	37,815
Total pending	419,970	381,014

The actual figures show a pending backlog substantially less than shown in the 1991 Independent Budget for Veterans Affairs, and that the backlog decreased from 1988 to 1989.

Question: 14. Please provide an estimate of the amount of resources (FTEE and funding) required to meet adjudication timeliness standards or goals in 1991.

Answer: Since timeliness of processing is directly related to FTEE and funding levels, we are making every effort in the 1991 budget to substantially improve the quality and timeliness of service we provide. Based on the positive trend shown in the chart below, we feel we can reach all timeliness standards in 1991 based on our current budgeted FTEE and funding levels.

Timeliness of Processing:

Type of Claim	Standard	12 Mo Cum SEP 88	12 Mo Cum SEP 89	Cur Month OCT 89	Cur Month NOV 89	Cur Month DEC 89
		(Percentages completed within 180 days)				
Compensation	70	70.3	68.5	70.6	71.8	72.4
Reopened	86	86.3	87.9	86.7	87.1	87.4
DIC	88	88.3	87.9	88.5	86.4	88.9
Pension	86	86.1	87.0	89.5	89.7	88.9
		(Percentages completed within 90 days)				
Income	89	89.1	90.8	90.8	90.7	91.7
Burials	87	87.7	89.1	90.8	91.5	90.4
Appeals	84	84.3	84.6	88.0	86.8	87.1
Death Pension	69	69.5	73.7	76.4	76.5	73.8

The data shown above is the total for all field stations and represents twelve month cumulative data for fiscal years 1988 and 1989, and current months data for the past three months. Six of the eight categories of claims processing timeliness showed improvements between end of year performance in 1988 and end of year performance in 1989. The other two categories have shown a recent trend of improvement based on the last three months of data.

Our estimates are subject to assessment of the impact of PL 101-237 on requirements for correspondence notifying claimants of denied claims.

VOCATIONAL REHABILITATION AND COUNSELING

Question: 15. Please explain how VBA can increase its accomplished work in the area of vocational/educational counseling when the 1991 FTEE is five less than 1990.

Answer: Through the use of contract counseling, VBA anticipates increasing its accomplished work in 1991 over 1990 even though the FTEE estimate has been reduced. A pilot program of rehabilitation for certain pension recipients (Chapter 15) and elective counseling for VA education programs was initiated at guidance centers during 1989 and continues in 1990. While it is too early to draw conclusions for all of 1990, the first quarter program data shows that fifty-one contracts are in force. For all of 1989, only nine contracts existed.

Question: 16. Please provide an estimate of the amount of resources (FTEE and funding) required to meet timeliness standards or goals in 1991.

Answer: The FTEE estimate for the Vocational Rehabilitation and Counseling Program would have to be increased by 73 FTEE in 1991 to achieve an average time in applicant status of 60 days and an average time in employment services of 200 days. The greater utilization of contract resources for Chapter 15 evaluations and educational and vocational counseling for Chapter 30 and Chapter 106, Title 10, will also have a positive impact on achievement of timeliness standards.

LOAN GUARANTY

Question: 17. Please explain the impact of a higher than anticipated default rate on the 1990 and 1991 budget estimates.

Answer: The number of home claim payments in 1989 (42,070) were 7,357 fewer than the historical high level in 1988 (49,427). It is expected that, due to continuing improvements in the economic conditions, the number of claims in 1990 (32,965) and 1991 (29,759) will continue to decrease by 9,105 and 3,206, respectively.

If the foreclosures are greater, it is estimated that the immediate impact on the Loan Guaranty Revolving Fund would increase the appropriation request by $30.8 million per 1,000 additional foreclosures in 1990 and $27.6 million in 1991. The increase in the appropriation amounts do not take into consideration the additional revenue that would be generated in subsequent years by selling some of the properties that were acquired (purchased by VA) during 1990 and 1991.

MEDICAL PROGRAMS

Question: 1. What would a $252 million supplemental support, if received 3/1, 5/1, 7/1?

Answer: It is the Department's position that no supplemental appropriation is necessary. VA Medical Centers are planning to complete this fiscal year within the current appropriations and looking beyond this year, the budget outlook is improved and reasonably predictable compared to last year. The change from an uncertain and reduced budget outlook to a predictable and upwardly oriented budget for next year has improved employee morale and it is expected cumulative employment will exceed 192,500 and we will treat more inpatients and outpatients than in FY 1989.

Question: 3. What is the equipment backlog figure?

Answer: The chart below delineates the backlog for object 31 Replacement Equipment and the Non-recurring Maintenance and Repair (NRM) program. This program is under review to determine the accuracy of the backlog amounts.

(dollars in thousands)

Replacement Equipment	1989	1990	1991
Prior Year	$393,315	$497,404	$637,797
Current Requirements	250,556	258,592	266,938
Total Requirements	643,871	755,996	904,735
Request	146,467	118,199	113,210
EOY Backlog	497,404	637,797	791,525

NRM

Prior Year	$326,185	$398,515	$509,355
Current Requirements	285,120	301,657	318,24
Total Requirements	611,305	700,172	827,60
Request	212,790	190,817	201,57
BOY	398,515	509,355	626,025

Question: 3. Why was the distribution of the $50 million for the Drug Abuse Program distributed $45 million for alcohol and only $5 million to drug treatment?

Answer: The $50 million was made available based on Section 2502 (b) of P. L. 100-690, the Anti-Drug Abuse Act of 1988, which states that any amounts appropriated under this subsection may be expended only for the purpose of providing care and services to veterans with alcohol or drug dependence or abuse disabilities.

Of the total $60 million ($10 million in the appropriation specifically for drug abuse treatment and the $50 million referenced above for both alcohol and drug) approximately $15.5 million is designated to purely drug treatment programs. Approximately $35.5 million is committed for Substance Abuse and Alcohol Treatment programs, Halfway House program and general support (ADP, program evaluation, education, etc.) for all abuse treatment programs. Most, if not all, of the remaining $9 million undistributed to date will be applied to drug abuse treatment.

The Substance Abuse and Alcohol Treatment program and the Halfway House program treat many veterans with multiple alcohol and drug abuse problems. While most patients on drug abuse treatment units will have a primary diagnosis of drug abuse, approximately 43 percent of patients on substance abuse units will have a primary or secondary diagnosis of drug abuse.

In summary, it is estimated that approximately $41.5 million of the $60 million total will be used to treat veterans with drug abuse problems. The following table shows a distribution of this total.

DRUG, SUBSTANCE & ALCOHOL ABUSE TREATMENT
1990 Congressional Add-On
(dollars in millions)

		-----Estimated-----	
	Total	Drug Portion	Drug % of Total
Distributed to Date for Treatment units (thru January 1990):			
Drug Dependence Treatment Program	$10.0	$10.0	100.0%
Substance Abuse & Alcohol Treatment	24.5	10.5	43.0%
Subtotal	34.5	20.5	
Other Commitments:			
Halfway House	2.5	1.1	43.0%
Compensated Work Therapy	5.5	5.5	100.0%
Subtotal Drug, Substance & Alcohol Treatment units	42.5	27.1	63.8%
General Support: 1/			
ADP, Program Evaluation, Education, etc	8.5	5.4	63.8%
Total Distributed and Committed	51.0	32.5	63.8%
Undistributed to Date:			
For Drug Abuse Treatment (estimate)	9.0	9.0	100.0%
Total Congressional Add-on	$60.0	$41.5	69.2%

1/ Same drug proportion used as Substance Abuse & Alcohol treatment already distributed.

2/ Although undistributed, it is assumed that most, if not all, will be applied to drug abuse treatment.

Question: 4. What is the status of the Nurse Pay Proposal and Physicians and Dentist Pay Proposals?

Answer: The VA's draft nurse and physician pay legislative initiatives are undergoing review within the Executive Branch from the standpoint of the Administration program. We will submit these initiatives upon completion of this review.

Question: 5. What is the plan to live within the MAMOE funding level since the reprogramming has been disapproved?

Answer: VHS&RA has obtained authority from the Office of Personnel Management (OPM) to offer a voluntary early-out retirement opportunity to its employees during the period of February 1, 1990 to March 31, 1990, and expects 12-15 employees to take advantage of this offer. It is taking vigorous steps to decentralize 12 physicians and dentists to the field, and expects to largely complete this process by 2/25/90. VHS&RA will also maintain the stringent controls on hiring it has had in place from August 2, 1989, to the present, and projects it will hire approximately 9 to 11 employees during all of FY 1990.

After taking these actions into account, a projected shortfall of $784,000 exists in the personal services accounts. To address this, VHS&RA is transferring funds from the other operating accounts into personal services as follows:

o $125,000 from travel
o $100,000 from consultants/contracts
o $100,000 from MIRMO
o $100,000 from supplies
o $100,000 from permanent change of station relocation costs

Additional funds will be transferred from these accounts as necessary and available. Future transfers are projected to come from the relocation costs account.

By making these dramatic reductions, MAMOE should be able to avoid having to furlough employees or utilize reduction-in-force procedures in FY 1990.

Question: 6. Where is the Medical Care Draft Reorganization Legislation?

Answer: Letters to the President of the Senate and Speaker of the House, forwarding draft legislation to waive the "reporting and waiting" requirements of Section 210(b)(2) of Title 38, United States Code for an administrative reorganization of VHS&RA's field operations, was signed by the Secretary of Veterans Affairs and dispatched on January 22, 1990. A report to Congressional oversight committees on this reorganization which reduces the member of regions and eliminates medical districts, was signed by the Secretary and dispatched on January 22, 1990.

Question: 7. How can the VA distinguish between service-connected disabilities and non-service connected disabilities of service connected veterans? Insurance companies in testimony are concerned that the VA can not.

Answer: MAS personnel at VA medical centers can determine a veteran's service connected disability by reviewing the documents that are located within the veterans administrative medical records at the time of application for medical care or admission. If these documents do not exist within the medical records or if the veteran is a first time applicant for care at that medical center, the MAS personnel can obtain the veterans disability rating and service connected conditions by accessing the HINQ system. When the disability information is obtained at the medical center via HINQ, the information is entered into the medical centers Decentralized Hospital Computer Program (DHCP). MAS personnel will then have access to the information needed to initiate the necessary preparation of the bill for the medical care cost recovery program.

Question: 8. How was the level of NIH and Medical Care support of Research determined?

Answer: Individual hospitals estimate that portion of their medical care funding that directly or indirectly supports the research effort. These research support funds were summed for all hospitals in the system to produce the actual 1989 level. The projection of an increase of support dollars in FY 1991 is based on the increase in total medical care appropriation in the President's request level.

The estimate of NIH support was based on trends over the last three years with the assumption that the NIH grants to VA would have the same percentage increase in FY 1991 as it had in the prior two Fiscal Years and the number of VA investigators available to compete for NIH funding would remain approximately the same.

Question: Provide a paper showing Construction projects not approved by OMB and the amounts in question. Also, show a priority listing of all construction projects, both those in the budget and those not approved.

Answer:

FY 1991 MAJOR CONSTRUCTION PROGRAM
OMB SUBMISSION VS. PRESIDENT'S BUDGET

(IN PRIORITY ORDER AS PRESENTED TO OMB)

FACILITIES	TITLE	BUDGET ($000) OMB	BUDGET ($000) PRESIDENT	SCORE
VHS&RA				
PALM BEACH	120 NHC	$ 10,200	$ 10,200	19.00
LAKE CITY	120 NHC	8,400		18.24
INDIANAPOLIS	CLIN & MH CENTER (CON)	79,400	79,400	14.38
MARION, IN.	GEROPSYCH FACILITY	43,400		14.38
BROOKLYN	O/P REPLACEMENT	41,000		14.37
KNOXVILLE	LAUNDRY REPLACEMENT	6,100		14.18
NASHVILLE	CLINICAL/PATIENT ENVIRON	48,000		13.86
DURHAM	CLINICAL ADDITION	6,400	6,400	12.65
DETROIT	NEW VA MEDICAL CENTER	260,077	240,077	11.62
TOGUS	CLINICAL IMPROVEMENTS	5,360	5,360	11.60
MARTINEZ	CLINICAL/SEISMIC(DES)	15,300	15,300	11.04
OKLAHOMA CITY	REPLACE SURGICAL SUITE	18,800	16,600	10.70
LONG BEACH	STRUCTURAL SEISMIC	65,000	67,200	10.40
GAINESVILLE	290 BED PSYCH BLD/PARKING	10,000		10.07
NEW ORLEANS	CONTRACTOR CLAIMS		3,300	*
PITTSBURGH	CONTRACTOR CLAIMS		3,100	*
	ADVANCE PLANNING FUND	20,000	12,500	*
	ASBESTOS	33,000	21,248	*
	DESIGN FUND	12,000	8,200	*
	HAZARDOUS WASTE	5,000	2,000	*
	PRIOR DESIGN FUND OFFSET	-6,395	-1,340	
TOTAL		$681,042	$489,545	
VBA				
MONTGOMERY	COLOCATION	8,000	8,000	*
NEWINGTON	COLOCATION	7,600		*
	ADVANCE PLANNING FUND	450	450	*
	DESIGN FUND	1,220	1,000	*
	PRIOR DESIGN FUND OFFSET	-780	-400	
TOTAL		$16,490	$ 9,050	
NCS				
FT. LOGAN	GRAVESITE DEVELOPMENT	3,300	3,300	*
FT. SHERIDAN	ESTAB NATIONAL CEMETERY	3,300		*
RIVERSIDE	PHASE 4 DEVELOPMENT	11,700		*
	ADVANCE PLANNING FUND	1,720	1,220	*
	DESIGN FUND	150	150	*
	PRIOR DESIGN FUND OFFSET	-900	-165	
TOTAL		$ 19,270	$ 4,505	
VACO	RENOVATE MAIN BUILDING	22,000	22,000	*
JUDGMENT FUND		11,300	4,900	*
TOTAL MAJOR CONSTRUCTION		$750,102	$530,000	
PARKING GARAGE REVOLVING FUND				
DETROIT	PARKING GARAGE	13,400		*
GAINESVILLE	PARKING GARAGE	12,300	12,300	*
INDIANAPOLIS	PARKING GARAGE	6,600	6,600	*
TOTAL PARKING		$ 32,300	$ 18,900	

* Prioritization methodology scores not available for these projects.

Question: Provide a white paper of the FDP process with emphasis on why it is so paper intensive.

Answer:

WHITE PAPER

Subject: The number of pages and paper copies needed to complete an FDP Study and what is done to minimize this number.

The Department of Veterans Affairs (VA) has outlined a minimal number of pages of information needed for the successful completion of an FDP study including the FDP itself. After streamlining the FDP process following the pilot tests, the VA initially expected the number to be 750 pages of text, charts and drawings excluding any reprint of appendix information from any previous stage. VA's actual experience is closer to a total of 600 pages average per FDP study. VA has also determined that 20-24 is the minimal number of copies needed during the FDP study phase.

To further reduce current and future paper needs, the VA is developing an electronic library of all FDP study information intended for wide use. The majority of FDP information is being collected using commercially available word processing and spreadsheet products that the FDP consultants have. This will limit the development costs to the government. This electronic library of information will become an important element of an integrated national planning database that will also draw on existing resources such as the Capital Facilities System; MEDIPP, and the Interactive Medical Facilities Planning System. This national database will allow better determination of system-wide needs and alternative long-range construction plans for meeting these needs within an environment of changing available resources.

VA is also outlining a basic process for doing routine updates to FDPs using this electronic medium, further reducing the need for paper copies.

GENERAL

Question:	1. Please provide a table showing, for each account and each major activity within each account, the original FY 1991 request submitted by the Department to OMB.
Answer:	The following table is the FY 1991 request submitted to OMB:

	OMB Submission	President's Request	Difference
Benefit Programs			
Compensation	$10,892,465	$11,286,856	$394,391
Pensions	3,843,000	3,762,052	-80,948
Burial Benefits	161,500	155,543	-5,967
Subtotal C&P	14,896,965	15,204,451	307,486
Readjustment Benefits	484,200	502,500	18,300
Veterans Insurance and Indemnities	15,410	15,410	...
Loan Guaranty Revolving Fund	370,600	512,200	141,600
Guaranty & Indemnity Fund *		80,800	80,800
Total Benefit Programs	15,767,175	16,315,361	548,186
Medical Programs			
Medical Care	12,631,289	12,227,066	-404,223
Medical & Prosthetic Research	216,795	198,537	-18,258
MAMOE	49,386	47,729	-1,657
Grants for the Construction of State Extended Care	42,000	42,000	...
Grants to the Republic of the Philippines	500	484	-16
Total Medical Programs	12,939,970	12,515,816	-424,154
Construction Programs			
Construction, Major Projects	750,102	530,000	-220,102
Construction, Minor Projects	193,909	145,640	-48,269
Parking Garage Revolving Fund	32,300	18,900	-13,400
Nursing Home Revolving Fund	...	-73	-73
Total Construction Programs	976,311	694,467	-281,844
General Operating Expenses & Misc.			
Veterans Benefits Administration	641,644	605,258	-36,386
National Cemetery System	59,055	54,806	-4,249
General Administration	257,687	242,450	-15,237
Total GOE	958,386	902,514	-55,872
Office of Inspector General	26,452	26,859	407
Grants for the Construction of State Veterans Cemeteries	3,717	3,946	229
Total GOE & Misc.	988,555	933,319	-55,236
Total Appropriations	$30,672,011	$30,458,963	$-213,048

* Permanent, Indefinite

NOTE: The President's Budget includes GS and SES payraise costs. These costs were not included in the OMB Budget request.

Question: 2. Identify the costs and funding for the 1991 payraise for all accounts.

Answer: The following table identifies the costs and funding for the 1991 payraise for all accounts:

1991 Payraise Funding and Costs
($ in thousands)

Revised 2/9/90

	Full Cost	50% Funding	100%
Funding			
Medical Care	$161,847		$161,847
Medical & Prosthetic Research	3,481	1,742	
MAMOE	910	455	
Construction, Minor	900	450	
General Operating Expenses:			
Veterans Benefits Administration	11,716	5,858	
National Cemetery System	1,008	504	
General Administration	5,206	2,603	
Total General Operating Expenses	17,930	8,965	
Office of Inspector General	1,047	814	
Total Department of Veterans Affairs	$186,115	$12,426	$161,847

Question: An article in the "Federal Times" dated January 8, 1990, stated that the VA will begin the new year with a shortfall of $158 million dollars and an additional $94 million shortfall in personnel costs due to an error in calculating average salary costs in FY 1990. Please provide the press release that was the basis for this article.

Answer: The VA did not have a press release on the FY 1990 shortfall. This information was provided to the press in response to a telephone inquiry. The information was furnished based on discussions with VSH&RA Resource Management Staff. The reporter from the "Federal Times" misinterpreted several points of information provided and presented some of the information out of context.

Question: a. Why is the GOE increase from FY 1990 to FY 1991 so much greater for BA than for outlays (see charts on pages 29-3 and 29-16)?

Answer:

	(dollars in thousands)		
	1989	1990	1991
Obligations incurred, net	$798,664	$811,628	$902,514
Obligated balance, start of year	77,288	101,917	64,931
Obligated balance, end of year	-101,917	-64,931	-72,202
Adjustments in expired accounts	- 7,574	...	...
Outlays	$766,461	$848,614	$895,243

As shown above, the normal end of year obligated balance for the GOE appropriation is approximately $60-70 million. At the end of 1989, however, that balance was $102 million. This balance is a consequence of the fourth quarter 1989 supplemental. The funds were used for the Loan Production System (LPS), maintenance and equipment in the National Cemetery System, and for automated data processing to support judicial review in the office of General Counsel.

Question: b. What was VA's request to OMB for the items in the charts on pages 23-9, 23-10, 23-17, 23-20, and 23-113? If the request to OMB didn't go into this detail, what were VA's assumptions about these items in arriving at the "summary" number that was submitted to OMB?

Answer: The 1991 budget allowance from the President was in total only. The distribution by item was left to the discretion of VA. Therefore, the information on pages 23-9, 23-10, 23-17, and 23-113 can not be provided. The VA's request was the following:

General Operating Expenses Analysis of 1991 Budget
(Chart on Page 23-10)

	($ in thousands)	
	OMB*	President's
Average Employment	17,482	17,168
Obligations:		
Personal Services	$ 636,258	$637,094
Travel	13,583	12,146
Transportation of Things	1,644	1,547
Rents, Comm., Utilities	185,239	165,112
Printing & Reproduction	7,149	6,226
Other Services	99,030	80,843
Supplies & Materials	17,606	16,658
Equipment	43,130	26,052
Insurance Claims & Indemn	450	375
Total Obligations	$1,004,089	$946,053
Reimbursements	- 45,703	- 43,539
Budget Authority	$ 958,386	$902,514

* The 1991 OMB request does not include funds for the payraise.

Veterans Benefits Administration
Object Classification Analysis (Chart 23-20)

	($ in thousands)	
	OMB*	President's
Average Employment	12,550	12,334
Obligations:		
Personal Services	$439,177	$438,361
Travel - Employee	8,136	6,794
Intra-agency Motor Pool	2,162	2,148
Local Travel	52	52
Subtotal, Travel	10,350	8,994
Transportation of Things	1,100	1,100
Rents, Comm., Utilities	101,796	89,355
Printing & Reproduction	3,794	2,939
Other Services	57,244	47,980
Supplies & Materials	5,048	4,363
Equipment	27,480	16,511
Total Obligations	$645,989	$609,603
Reimbursements	-4,345	-4,345
Budget Authority	$641,644	$605,258

* The 1991 OMB request does not include funds for the payraise.

General Operating Expenses Analysis of 1991 Request

	($ in thousands) OMB*	President's
Obligations:		
Veterans Benefits Administration	$645,989	$609,603
National Cemetery System	59,800	55,264
General Administration	298,300	281,186
Reimbursements	-45,703	-43,539
Total, GOE Budget Authority	$958,386	$902,514

* The 1991 OMB request does not include funds for the payraise.

	OMB*	President's
Average Employment:		
Veterans Benefits Administration	12,550	12,334
National Cemetery System	1,328	1,276
General Administration	3,604	3,558
Total, GOE Average Employment	17,482	17,168

Question: c. Page 6-28 states that the budget includes increases of $412,000 for continuing education of VAMC staff, tuition support, and tuition reimbursement. What was VA's request to OMB for this account?

Answer: The request to OMB was for an increase of $323,000 in 1991 for continuing education, tuition support and tuition reimbursement. That increase was revised to $412,000 in the 1991 Congressional budget submission. Note that the 1991 budget allowance from the President was in total only. The distribution by item was left to the discretion of VA.

Question: d. What was the VA's request to OMB for the items in the chart on pages 6-29 and 6-31?

Answer: The VA's request is the following:

Page 6-29 PAYROLL

	($ in thousands) President's	OMB
FECF	$ 10,035	$ 5,197
Workday change	27,823	27,769
Stipend increase	10,041	10,041
Social Security increase	18,488	16,913
Medicare	480	482
FERS	30,358	22,645
Within grade increases	62,391	62,893
Special salary rates	50,000	97,300
1990 Payraise annualization	81,608	80,665
1991 Payraise	161,847	...
Total	$453,071	$323,905

Page 6-31 INFLATION

	President's	OMB
Increase cost-inflation	$183,922	$195,357
Real property rental rate	467	492
Subtotal	184,389	195,849
State veterans homes	2,748	2,815
Other Non-VA programs	45,161	49,238
Total	$232,298	$247,902

NOTE: The 1991 budget allowance from the President was in total only. The distribution by item was left to the discretion of VA.

Question: e. Page 6-34 states that an additional $25,180,000 in Medical Care account funding is requested for FY 1991 "to support computerized systems equipment acquisitions." (See written question 67) What was VA's request to OMB for these acquisitions?

Answer: The computerized systems equipment acquisition portion of the 1991 request to OMB was $25,237,000.

NOTE: The 1991 budget allowance from the President was in total only. The distribution by item was left to the discretion of VA.

Question: f. Page 6-34 notes that a total of $101,766,000 is requested for FY 1991 for object class 32 (lands and structures) under the Medical Care account. What was VA's request to OMB for object 32 and for each of the four subcategories on page 6-34?

Answer: See the following chart:

	($ in thousands) President's	OMB
Lands and structures		
Replacement	$ 19,027	$ 28,517
Additional	6,505	11,567
Minor Improvements	13,562	30,393
M&R (Capitalized)	62,672	95,268
Totals	$101,766	$165,745

NOTE: The 1991 budget allowance from the President was in total only. The distribution by item was left to the discretion of VA.

Question: g. What Medical Care account ADP funding and FTE requests included in VA's original FY 1991 submission to OMB are not included in the President's budget?

Answer: The 1991 Medical Care ADP request to OMB was $158,755,000 and 1,675 FTEE. The President's budget request for ADP was $165,872,000 and 1,688 FTEE. Two initiatives requiring small amounts of ADP resources were not included in the President's budget. They were for GRECC expansion and GRECC research. These reductions were offset by base changes to reflect actual charges, payraise increases, and field reprogrammings for ADP priorities.

NOTE: The 1991 budget allowance from the President was in total only. The distribution by item was left to the discretion of VA.

Question: h. Page 23-44 states that the requirement in Public Law 101-237 that VA provide detailed information to unsuccessful benefits claimants will have an adverse effect on claims processing timeliness. What additional funds and FTE would be required to nullify this effect (and maintain current timeliness)? Did VA request these additional resources?

Answer: Our initial estimate is that as many as 145 additional FTEE will be needed to implement the claimant notification requirement of PL 101-237. We will conduct a formal work measurement study shortly which will enable us to replace this estimate with a firm figure. In addition, preliminary estimates indicate the need for additional automated equipment to handle the increased correspondence workload. Costs of this equipment could go as high as $2 million, pending further analysis.

The additional resources were not requested because PL 101-237 was passed after the FY 1990 appropriation and the formulation of the FY 1991 budget request.

Question: i. Why are no funds requested for "Computer/components" for FY 1991 (see page 23-187)?

Answer: The line-item in the budget request for Computers/components refers only to the purchase of automated data processing and office automation equipment. Although no equipment will be purchased in FY 1991, VA will acquire additional computer equipment by leasing hardware to implement mainframe system initiatives at the Austin Data Processing Center (DPC). These additional costs are included in the line-item for Lease of Computer Equipment.

The lease of new hardware has several advantages over the purchase of this kind of equipment. A lease/purchase analysis for planned systems enhancements at the Austin DPC demonstrated that it is more cost-effective to lease the required hardware than to purchase it. Leasing this equipment will also allow VA the flexibility to acquire new technologies as they become available. In addition, the information resources management requirements of VA users can be more easily accommodated with the flexibility that lease arrangements provide.

Question: j. The "1989 Program Highlights" on page 23-187 seems to include activities that occurred in FY 90. Is that correct?

Answer: No. All 1989 Program Highlights included in the budget submission are for activities that were conducted in fiscal year 1989.

Many of the activities included in the highlights section of the budget request are on-going in 1990, such as the Nationwide Office Automation for VA (NOAVA) project, the preparation of annual reports, the establishment and revision of Service Level Agreements, and implementation of the Integrated Data Communications Utility (IDCU). New initiatives planned for 1991 are identified on pages 23-180 and 23-181.

Question: k. Page 23-194 indicates VA plans three program evaluations in FY 1991. How does this compare with the evaluations carried out directly or by contract in FYs 1988 and 1989 and planned for FY 1990?

Answer: The FY 1991 budget request will enable the VA to conduct a total of five or six program evaluations using a combination of in-house staff and contracted consultant efforts. Up to three of these will be by contract. A new program evaluation process was approved by the Secretary on February 9, 1990, which uses a meta-analysis approach. This approach relies heavily on studies and analyses conducted by the General Accounting Office, the VA Inspector General, and program officials, as well as existing data from management information systems. Twenty-four program groups have been identified for evaluation purposes, and a plan to evaluate these on a five-year cycle is currently being developed. The plan will identify program groups to be evaluated in each fiscal year for the period FY 1990 through FY 1994.

Previous year's evaluations completed were:

FY 1988
Therapeutic Work Program (in-house)
Surgical Planning Process (in-house)
Library Service (in-house)
Education Approval Process (in-house)

FY 1989
Restored Entitlement Program for Survivors (in-house)
Nursing Home Care Programs (contract)
Chapter 30 Education Program (contract)

We expect to evaluate the following programs in FY 1990:
Dietetics (in-house)
Vocational Rehabilitation (contract)
Homeless Veterans (in-house)
Post-traumatic Stress Disorder (PTSD) (in-house)
Housing Loan Program (contract with delivery in early FY 1991)

Contractual funds are obligated upon award of the contracts; the funding for evaluations was obligated as follows:

Evaluation	Fiscal Year	Amount
Nursing Home Care	1987	$399,490
Chapter 30 Education	1988	124,406
Vocational Rehabilitation, Phase 1	1988	309,263
Vocational Rehabilitation, Phase 2	1989	154,537
Housing Loan Program	1990	

Question: l. What were the annual receipts from "Fees and other charges for medical services" for FY 1989 and estimated for FY 1990 under current law? Please break this down into "deductibles and other charges" and "third party collections."

Answer: The following table breaks down the annual receipts from "Fees and other charges for medical services" under current law:

	FY 1989	FY 1990
Deductibles and other charges	$ 12,520	$ 12,500
Third party collections	133,483	135,500
Total annual receipts	$146,003	$148,000

Question: m. State the total amount and number of State Home construction grants, in addition to those for which funding would be available under your FY 1991 budget, that would be approvable and could be made in FY 1991 if funding for all approvable applications were provided.

Answer: The August 15, 1989, priority list of applications for State home construction grants contained 50 eligible applications totaling $172 million. There were 25 priority group 1 applications. These are applications for which States have provided sufficient State matching funds. Of the 25 priority group 1 applications, eight were funded with Fiscal Year 1989 funds. That leaves 17 group 1 applications unfunded during FY 1990. Our FY 1990 appropriation of $41.3 million will enable us to fund five of the 17 applications, leaving a total of 12 for which we do not have available funds, totaling about $16.6 million.

We will not know how many additional priority group 1 applications will appear on the august 15, 1990, priority list for funding in Fiscal Year 1991. States have until August 15, 1990, to obtain State matching funds and submit documentation showing that they qualify for priority group 1. We are expecting many applications to qualify for group 1 and it is unlikely that our $42 million budget request will fund all the qualified applications.

Applications are not approved until State and Federal funds are available until States have met all Federal requirements. This includes State and Federal review an approval of design documents, environmental compliance, historic preservation compliance, and others. This entire process at a minimum requires 10 to 12 months. We believe that if Federal funds were available, and the States were told that Federal funds were available, the States could meet the Federal requirements and we could fund about 95 percent of all applications we have on hand at this time.

Question: n(1). How many additional telephone circuits (in addition to those already in operation and those for which funding is provided in the FY 1990 or FY 1991 budget), by line group, will be needed in FY 1991 to provide a grade of service whereby nine out of ten callers will be able to access the VA telephone interview activity on their first try?

Answer: We cannot provide a definitive answer to this question at this time due to the transition to FTS-2000. The Department of Veterans Affairs was assigned to US Sprint for telecommunications requirements, including toll-free service, through the life of the GSA FTS-2000 contract. US Sprint has agreed to design and recommend access arrangements for the toll-free telephone service program at each of the 57 regional offices (excludes Manila). We cannot provide a specific response as to the number of additional lines needed until we receive US Sprint recommendations. These configurations will be in compliance with the GSA original request for proposal (RFP) requirements for a B.07 grade of service.

Currently there are 399 local, 202 800-service and 268 foreign exchange (EX) lines installed nationwide. There is no proposal to change the number of circuits in either the 1990 or 1991 budget.

During the FY 1991 budget formulation process, a review of our blockage indicated a need for the following:

Line Group	Number of Circuits	Projected Costs
Local	17	$ 9,843
800-service	32	461,760
FX	32	142,240
TOTAL	81	$613,643

However, these projections were based on AT&T circuitry which we have since learned is no longer available for our use. As a result of the FTS-2000 contract, US Sprint is the only vendor from whom we may purchase lines.

Question: n(2). What would be the estimated cost of acquiring those additional lines in FY 1991?

Answer: While we cannot provide a dollar figure at this time, US Sprint service initiation charge is based on the type (800-service and FX service) and number of lines installed. Sprint's proposal for reconfiguring each field station's toll-free service (see question n(1)) will include an estimate of the initiation charge, monthly recurring costs and a comparison of the proposed vs. the existing configurations usage costs.

An additional cost associated with the installation of any additional circuits is the placement of intercept messages on the disconnected AT&T circuits. This cost is based on the number of months the intercept message is available to VA callers and the number of calls intercepted.

Question: n(3). What would be the additional FY 1991 costs (in FTE and funding) of covering the additional lines and maintaining in FY 1991 --

A. a 10-percent abandoned call rate, or

B. a 5-percent rate?

Answer: Only 7.5 percent of the callers reaching the VA in FY 1989 abandoned their attempt to talk with a veterans benefits counselor (VBC). Using existing circuitry and current staffing levels, we expect the percentage of abandoned calls to remain within the 10 percent standard through FY 1991.

In FY 1991, we expect approximately 10.1 million callers to reach the VA. Using our current standard of 10 percent abandonment, 9.1 million callers will talk with a VBC and one million callers will hang up before talking with a VBC.

Approximately three million callers will receive a busy signal or have their calls blocked in their first attempt to reach the VA. Based on our current standard, permitting 10 percent of the callers to receive a busy signal in their first attempt, and the established retrial tables, approximately 518,000 callers will not try calling the VA again. Additional circuitry will allow these callers to reach the VA. To provide service to these callers and to maintain a 10 percent abandoned call rate, an additional 54 FTEE (GS-9) would be needed at a cost of approximately $1,775,000.

If we improved our standard for abandonment to five percent, only 500,000 callers will hang up. To provide service to 500,000 callers who previously would have abandoned plus the additional 518,000 callers reaching the VA in their first attempt, an additional 107 FTEE (GS-9) would be needed at a cost of approximately $3,517,000.

Question: n(4). What standards do other large government agencies and private sector companies with comparable volume use for blocked and abandoned calls?

Answer: A provision of the GSA FTS-2000 contract requires the vendor to design and recommend a configuration to provide a B.07 grade of service. Agencies may request a lessor grade of service to meet certain government requirements.

Social Security Administration's 800 telephone service provides public access via a single 800 number. They are striving for an average busy signal rate of five percent or less, no more than 50 percent of the calls placed on hold, with the maximum average wait time on hold not to exceed 60 seconds. Approximately 55 million calls are handled annually.

The Internal Revenue Service's standards of accessibility for their toll-free telephone assistance program are reviewed and revised annually. The funding level for the program determines their standard. Their past or present standards were not made available to us.

Generally, private industry provides a B.01 level of service to their customers due to their profit motive.

Question: o. Will the advanced procurement plans for call-handling equipment in FY 1991 and beyond simply maintain and replace current equipment, or do you plan to consider consolidating telephone interviewing activities and thereby require fewer pieces of equipment with larger capacity?

Answer: There is no current plan to consolidate or centralize our telephone interview activities. However, we are reviewing alternatives to our current method of providing telephone service. Any restructuring of the VBA toll-free telephone program must assure high quality services that are responsive to the needs of the callers and reduce costs. Stations will continue to include in their advance procurement plans the type of call-handling equipment necessary to meet the technological needs of the program.

Question: p. Please provide a brief description of each of the Automated Data Processing initiatives that were included in VA's original FY 1991 request to OMB but deleted in the OMB passback, and an assessment of the effect that a delay until FY 1992 will have on program efficiency and the modernization effort.

Answer: The request to OMB had several items that as a result of budgetary considerations were excluded from the 1991 budget submission. Briefly those included: (It should be noted that in the passback for 1991 on this and several other items, the agency was encouraged to resubmit for the 1992 budget the LPS II request once an adequate accounting of costs to Austin DPC and RO's and a benefit analysis to Loan Guaranty Revolving fund were completed.)

Loan Production System. Phase II of the Loan Production System (LPS) included three separate but related efforts. These were:

LGY Index- This involves creation of a nationwide entitlement and loan index, which would provide generalized access to the status of loans, eligibility and entitlement for all veterans and properties involved in the VA Loan Guaranty Program. This would resolve a number of long-standing problem areas including fraud and abuse prevention, debt management and credit review.

Liquidation and Claims System (LCS) Replacement - Greatly enhanced support for all RO level business associated with LCS processing will be added to the LPS architecture. Concurrently, the central batch processing (LCS) would be replaced and downsized, in conformance with long range VBA goals of open architecture and platform independence.

Portfolio Loan System (PLS) Replacement - This effort would streamline the existing PLS application with more efficient support from an operational point of view. Because of the parallelism between the VBA and commercial portfolio management requirements, it is anticipated that a modified commercial package could meet our needs.

Delays in funding this initiative will extend the period of high delinquency and foreclosure rates that have stemmed from the VA's inability to adequately check for previous payment problems of loan applicants.

The current Loan Service and Claims processing units, which would have their workflow automated through a redesigned LCS system, are today completely paper driven and contribute greatly to VBA's paper backlog. Delay in automation of the LS&C activities may contribute to delays in operations in the event of unusual loan activity.

Our preliminary analysis indicates that a potential savings of $29 million could be realized upon implementation of these initiatives to the LGY Revolving Fund each year. These savings result from reapplication of FTE saved through automation of the LCS process to loan servicing activities, thereby reducing the foreclosure rate. Savings estimates are based on the increased availability of manpower for counseling of veterans who are in danger of losing their homes through foreclosure. To the degree this project is successful, it would serve not only the good business purpose of decreasing government expenditures but also the very human purpose of assisting veterans and their families in retention of their homes.

Insurance Technology Upgrade.

A request was made to correct weaknesses that exist in the software technology and architecture upon which the VBA Insurance program depends in the administration of policies and payments to beneficiaries. The lack of adaptability of the existing technology has been identified as an Agency Material Weakness.

Within the request for 1991, VBA would have proceeded with plans for conversion to a single primary system. This architecture is both flexible and easy to maintain and allows for design efficiencies when incorporating changes. Without additional funding no progress will be made on redesign of the Insurance system. This initiative would bring the Insurance system to a state in which it could be reliably operated and maintained, thereby enabling a transition to VBA's long-term modernization solution.

Two-year Funding Authority. VBA sought multi-year funding authority in order to provide the flexibility needed for potential procurement delays which are outside of VBA control. This request was denied as a result of the short term nature of the investments.

Long-Term Solution. Funding was requested to conduct an operational test in a Regional Office which builds upon the mid-level migration (gateway) initiative. The purpose of this initiative, which is now underway, is to remove the constraints of proprietary communication methods currently utilized by VBA.

The operational test proposed for 1991 would assess the interconnectivity of existing equipment provided by multiple vendors. A successful test would result in Regional Office staff being able to access office automation and other functions from a Target workstation, and Target information from non-Target workstations. The test would make use of commercially available local area network products as opposed to VA-specific custom-developed solutions. If successful, the test would be expanded to integrate the interchange of image information within the Regional Office. The request was deferred pending the results of functional requirements analyses to determine the complexion of long range decisions and a outcome of cost alternatives

Optical Disk . The Optical Disk prototype project in St. Louis has recently been enhanced through various software improvements. Following these enhancements, the evaluation contractor is now in the process of updating the performance statistics and will provide a final evaluation report in March 1990. Beginning in December 1989, the optical disk equipment in St. Louis will be in a state of transition to a maintenance mode. The equipment and software will continue to support Chapter 30 claims processing at St. Louis until replaced by equipment to be procured by the stage two modernization acquisition.

This enhanced prototype would explore methods for distributing imaging technology as well as dual capture of images and text to provide automated indexing at the time of image scanning, and to eliminate the need to manually input data. The transmission of images would also be tested along with various imaging software packages. The results of this prototype would directly feed into the stage two modernization procurement and failure to fund the prototype in 1991 could impede the current implementation schedule. OMB is requiring the outcome of the St. Louis project to determine feasibility of the 1991 request.

Integrated Target/Office Automation Access for Itinerant Employees. This initiative would provide for acquisition of portable computing equipment for VBA field examiners. Improvement in communications and access to VBA's data systems is a necessary prerequisite to increased supervision of beneficiaries. Improved Field Examiner productivity, marked improvement in timeliness and quality and more effective management control have been effectively demonstrated by the Model Station prototype system. The initiative is capable of producing significant gains in overall program effectiveness while holding program expenditures at a relatively constant level in out years.

The availability of current information for Field Examiners and the exchange of information between Field Examiners and supporting regional offices are cornerstones of our efforts to upgrade the overall quality of the Fiduciary (F&FE) program and improve beneficiary protection objectives. Program effectiveness and the level of protection afforded the beneficiary are directly related to the currency, completeness and accuracy of the information available to the Field Examiner. The initiative provides access to needed information and the ability to communicate efficiently based on word processing capability.

The Itinerant initiative is an integral part of VBA's emphasis on quality and service improvement. The absence of funding precludes our ability to improve detection and prevention of fraud, waste and abuse in a major program area comprising over $1 billion of annual benefit payments to 124,000 VA beneficiaries.

Six Additional FTE for Central Office. VBA requested six additional FTE for ADP Systems Management in Central Office. These FTE would support network and system performance management and OA systems integration.

Chapter 106 Redesign . A request to contract support for a redesign of this system was made.

On-Line HEIR System for Education . This initiative provided for development of a requirements analysis to incorporate interactive help messages and procedural guidelines into claims processing systems used in regional offices. The current process requires reference to multiple manuals and circulars to obtain guidelines and procedures necessary for claims processing. Modernization will bring new ADP technologies that can increase automation in this area but effective use of these technologies cannot be realized without a clear understanding of what information needs to be accessible at each step in claims processing. This initiative would enhance claims processing in the ROs.

Remittance Processing System Replacement . The primary reason for replacing the remittance processing system is to provide for normal replacement of capital equipment which will reach the end of its system life cycle at the end of FY 1991. Although some marginal productivity improvements would be achieved with the new remittance processing equipment, the request for replacement is based on the need to operate the system on efficient and reliable equipment in the future.

Veterans Assistance Quality Management. The Veterans Assistance Service plan is to install recording devices for the incoming public telephone circuits that terminate in the telephone interview activities nationwide. These recording devices will select random telephone calls and record them for later review, both locally and at a centralized point (VACO controlled). The recorded conversations will allow local supervisory review with the backup support of the recording to demonstrate to the counselors what needs to be improved. The conversations may be evaluated whenever convenient for the supervisor, thereby allowing better control over the work day and supervisory functions. From a centralized standpoint, reviews can be evaluated by Central Office personnel or by a team of field supervisors, as desired, and will provide information for nationwide training plans and budget formulation. This request would serve to improve quality and timeliness in service delivery.

Question: q(1). To what degree will the use of contract counseling reduce the vocational rehabilitation caseload for VA counselors and specialists in FY 1991?

Answer: The VR&C program field divisions are in the process of establishing contractual guidance center contracts and have increased the number from nine in fiscal year 1989 to 51. Additionally, contractual arrangements for chapter 15 evaluations are used where this will alleviate the workload of counseling staff. The impact on this workload will be minimal since the contract counseling for chapters 30 and 106 will expand counseling services to a currently under-served population of recently discharged veterans and reserve participants.

Question: q(2). What would be the FY 1991 costs (in funds and FTEE) of bringing VA's vocational rehabilitation counselors' and specialists' caseloads within current VA standards?

Answer: Resources to meet these standards are represented by the addition of 73 FTEE at a cost of $2.529 million in FY 1991 for case management of veterans receiving services in programs of rehabilitation. This would allow reduction of caseloads from the current 222 cases per case manager to 150. Additionally, this would allow the reassignment of 27 FTEE counseling psychologists who are currently helping the case management effort by: devoting time which would otherwise be available to accomplish direct labor counseling/evaluation service.

Question: q(3). What are the current standards?

Answer: The current standard for caseload is an ideal of 125 and an acceptable level of 150 per case manager. This is contrasted with caseload averages of 125 in the State-Federal rehabilitation programs and 30 to 60 clients in private rehabilitation. An acceptable or ideal caseload will significantly increase the number of successful rehabilitation outcomes for the program.

Question: r. The Inspector General issued a report on January 11, 1990, of his "Audit of Temporary Interest Rate Buydown Loans" (No. 0R5-B10-015). The audit revealed that 46 percent of foreclosures on interest-rate buydown loans guaranteed by VA resulted in a failure to credit the full amount of the buydown to VA and the veteran-borrower, resulting in $1.8 million in VA overpayments, $1.8 million in corresponding overstatements of veteran's debts, and $608,083 in avoidable interest costs to the Treasury. The report states that the Chief Benefits Director refused to identify and correct the overpayments and overstatements of veterans' debt connected with buydown loans not identifiable through automated systems, "based on a lack of resources to accomplish the file search."

(1). The Inspector General forwarded the unresolved portion of the audit to the Deputy Secretary for resolution. When will the Deputy Secretary decide this issue?

Answer: Since January 11, 1990, when the Acting Inspector General forwarded the audit for resolution, both VBA and OIG have been working together to reach consensus on the unresolved issues. While no date has been established for the final decision, we will advise you when a decision has been made.

Question: r(2). Please state the funds and FTEE required to comply fully with the recommendations of the Inspector General.

Answer: The following cost analysis includes costs to the Department as well as the Government to execute the OIG recommendation. Estimates of costs to the Government include payroll costs at the Federal Records Centers which are outside VBA's span of influence.

Costs Associated with Folder Processing	
Payroll (23 FTEE)	$ 530,835
File cabinets	100,080
Space rental	83,483
Mail	604,800
Subtotal (Federal Records Centers)	$1,319,198
VA Program Costs	
Loan Guaranty processing costs (8 FTEE)	$ 140,600
Finance processing costs (2 FTEE)	37,135
Subtotal (VA)	$ 177,735
Total cost to comply with the OIG recommendation	$1,496,933
Total FTEE required	33

Question: r(3). Please state the funds and FTE required for any alternative to address this problem, such as notifying all veterans who might be entitled to relief from a portion of their debt (but not identifiable as so entitled through automated systems).

Answer: The following is a cost analysis to implement VBA's proposal to review the known buydown claim payments and is based upon similar assumptions as those used to answer the previous question.

Costs Associated with Folder Processing	
Payroll (.9 FTEE)	$ 30,327
File cabinets	...
Space rental	...
Mail	23,829
Subtotal (Federal Records Centers)	$ 54,156
VA Program Costs	
Loan Guaranty processing costs (1.4 FTEE)	$ 37,183
Finance processing costs (.9 FTEE)	22,797
Subtotal (VA)	$ 59,980
Total cost to comply with the VBA's recommendation	$ 114,136
Total FTEE required	3.2

With respect to the proposal to notify veterans who might be entitled to relief, we believe the notification would create more ill will than be of benefit to the individual veteran. The Office of Inspector General estimates that 6,630 veterans may be entitled to a debt reduction of $272.87 when veterans debts have been averaging over $13,000 in recent years. VBA has agreed to review 2,762 of the 6,630 cases leaving a remainder of 3,868 veterans with a potential debt reduction of $272.87. In order to notify the 3,868 veterans, VBA would have to inform 107,109 veterans that they may be entitled to a debt reduction. As an alternative, when veterans request a waiver, the Loan Guaranty operation can review the file and determine whether an adjustment is appropriate.

Question: r(4). Please describe the steps VA has taken or will take to prevent this problem from recurring.

Answer: In conjunction with reaching a final resolution to the audit recommendation, VBA has been preparing instructions to implement all audit recommendations and to provide instructional material for coding and claims personnel located at field stations.

Question: s. On February 14, Assistant Secretary David Lewis was kind enough to provide, at my request, a list (FY 1991 Major Construction Program OMB Submission vs. President's Budget) comparing major construction projects included in VA's submission to OMB with those included in the President's budget and indicating the VA priority score associated with each project.

s(1)(A). Were any projects rated at 10.07 or higher not included in VA's request to OMB?

s(1)(B). If so, what are these projects, what are their priority scores, and why were they not included in the VA request?

Answer: Yes. The projects rated at 10.07 or higher were not included in VA's request to OMB.

The following is a list of projects that the Department considered for submission in the FY 1991 major Program which were not sent to OMB. The Palo Alto project was not included because at the time it was not sufficiently developed for budget entry. Subsequently the design funding for this project has been provided as part of the response to the Loma Prieta earthquake.

In finalizing the VA budget submission to OMB, priorities were established based primarily on the results of the methodology and prior year initiatives by the Congress through previous design appropriations e.g. Detroit and Indianapolis. It was determined in the Department to request a budget level for major construction of approximately $750 million. The projects listed below could not be included within the limits of this funding level.

		($000's)	Score
AUGUSTA	SCI EXPANSION	$24,100	14.66
NORTHPORT	MODERN. PSYCH & OP	40,500	14.29
TUSCALOOSA	RENOVATE B-38/CONST 270 PSYCH BLDG	49,200	14.26
PALO ALTO	SEISMIC/BED ADDN (DESIGN)	5,400	14.13

Question: s(2)(A). Were any projects rated between 9.0 and 10.07 not included in VA's request to OMB?

s(2)(B). If so, what are these projects and their ratings?

Answer: There were no projects considered by the Department with scores in this range.

Question: t. What was VA's request to OMB for the items in the charts on pages 6-50, 6-51, 6-53, 7-11 (BA only), and 7-14? If the request to OMB didn't go into this detail, what were VA's assumptions about these items in arriving at the "summary" number that __was__ submitted to OMB?

Answer: Obligations by Object (dollars in thousands)
(pages 6-49, 50)

	OMB
Personal Services and Benefits	$ 7,657,508
Travel & Transportation of Persons	123,935
Transportation of Things	19,637
Communications, utilities & other rent	452,211
Printing and Reproduction	15,246
Other services	1,632,521
Supplies and materials	1,910,062
Equipment	603,895
Lands and structures	165,745
Grants, subsidies & contributions	110,529
	$12,691,289

The difference between OMB and the Congressional request is because of the 3.5% payraise and the use of 1989 actuals to project the 1991 Congressional numbers. The OMB numbers included initiatives which were not selected for inclusion in the Congressional budget.

Residency and Other Training Programs (page 6-51)

Total Average Employment	6,796
Total Obligations	473,283
Number of health professional trainees	98,935
Continuing education of VAMC staff:	
Obligations	10,098
Participants	173,500

Non-VA Program Summary (page 6-53)

Contract Hospitals:

Census	486
Per diem	$1,130.17
Direct Obligations ($000)	200,481
Support Obligations ($000)	7,796
Total Obligations ($000)	208,277
FTE (support)	165

Community Nursing:

Census	11,580
Per diem	$81.86
Direct Obligations ($000)	345,998
Support Obligations ($000)	36,436
Total Obligations ($000)	382,434
FTE (support)	840

The change in obligations from the OMB to the Congressional budget is based upon carrying forward the 1990 ADC level into 1991. The 1990 level results from sequestration and an internal reprogramming to support inpatient VA workload and employment.

State home doms:

Census	4,307
Per diem	$9.59
Direct Obligations ($000)	15,076
Support Obligations ($000)	2,625
Total Obligations ($000)	17,701
FTE (support)	46

State home nursing homes:

Census	11,161
Per diem	$22.44
Direct Obligations ($000)	91,415
Support Obligations ($000)	4,119
Total Obligations ($000)	95,534
FTE (support)	86

State home hospitals:

Census	493
Per diem	$22.44
Direct Obligations ($000)	4,038
Support Obligations ($000)	848
Total Obligations ($000)	4,886
FTE (support)	17

NOTE: The 1991 Medical Care budget allowance from the President was in total only. The distribution by item was left to the discretion of VA.

The VA's request to OMB for the charts on pages 7-11 and 7-14 are as follows:

Page 7-11 - Budget Authority Only - dollars in thousands

Medical Research	$ 185,112
Rehabilitation Research	22,734
Health Services Research	8,949
Total Request	$ 216,795

Page 7-14 - Budget Authority by Sub-Activity

Investigator-Initiated	$ 148,066
Cooperative Studies	9,700
Career Development	19,642
Special Research Initiatives	6,107
Agent Orange	1,597
Total	$ 185,112

Dr. Elliott Fisher's Reply to Post-Hearing Questions Submitted by Senator Alan Cranston

1. Please describe how you and your colleagues divide up a typical week -- recognizing that no week is "typical" -- both among clinical, research, and administrative responsibilities and between VA and the affiliated medical school.

For the first two years, I spent approximately half of my time in clinical activity at the VA hospital. Most of this was providing direct patient care in my own clinic or in the "drop-in" clinic. For the last 18 months, I have been directing a project (80% time) that uses both the Patient Treatment File (the VA's computerized database) and Medicare's computerized databases to (1) evaluate the utilization and outcomes of hospital treatment in the VA, (2) assess the extent of cross-utilization between the two systems of care, and (3) to attempt to compare patterns of care across the two systems. The computer and staff resources for this project are based primarily at the Hanover campus. Consequently, I have been spending most of my time away from the VA. If we continue to be successful in securing VA funding, we expect to move our research program to the VA when our new research building, which is currently under construction, is completed. My typical week looks like this:

- 1/2 day at the VA providing clinical care -- supported by my research funds
- 1/2 day meeting with VA clinical staff on research efforts
- 3 days supervising the analyses for the VA research project
- 1 day working on research projects supported by non-VA sources

2. If research funding continues to be awarded to fewer and fewer physicians with meritorious proposals, which types of physicians (by specialty or tenure) -- if any -- do you think VA would lose first? Where would they go?

The AFCR has done no formal analysis regarding specific groups of physicians who will leave the VA if they no longer receive research support. However, we do know that all physician-researchers are feeling the impact of a severely constrained research budget and that many are beginning to reconsider careers in the VA.

3. A review of the Medical and Prosthetics Research Account budget makes it apparent that, due to the cut in VA-provided funding, the research budget relies on increases in non-VA-designated research support to maintain an even keel. I am concerned, however, that the assumptions VA made in calculating expected funding from NIH grants and direct or indirect in-kind contributions through the medical care appropriations may not be correct. Please comment on the trends you see in NIH research funding and how NIH and VA research funds are allocated.

NIH support has been unstable in recent years. In 1985 the agency was able to fund 6500 research project grants, while in 1990 it will fund only 4633 grants. In this uncertain environment, physicians at the VA cannot depend on NIH research support. They have no better chance of receiving NIH support than other university-based researchers not affiliated with the VA. Thus it is completely unrealistic to think that VA research can be in any way supplemented by NIH support.

THE INDEPENDENT BUDGET PROJECT
Funding Proposals for Veterans' Programs

March 5, 1990

The Honorable Alan Cranston
Chairman
Senate Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

Pursuant to you letter of February 27, 1990 we are enclosing responses to your questions in follow-up to the February 23 Senate Committee on Veterans' Affairs' hearing on the proposed FY 1991 budget for veterans programs.

The responses represent the combined view of the Independent Budget sponsoring organizations, AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars.

Thank you for your continuing consideration.

Sincerely yours,

Robert L. Jones
Executive Director
AMVETS

A Joint Project of:

AMVETS
4647 Forbes Boulevard
Lanham, Maryland 20706
301/459-9600

DISABLED AMERICAN VETERANS
807 Maine Avenue, S.W.
Washington, D.C. 20024
202/554-3506

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, N.W.
Washington, D.C. 20006
202/872-1300

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Avenue, N.E.
Washington, D.C.
202/543-2239

THE INDEPENDENT BUDGET PROJECT
Funding Proposals for Veterans' Programs

Follow-up Questions and Responses For February 23, 1990 Senate Committee on Veterans' Affairs Hearing on the FY 1991 Budget for the Department of Veterans Affairs

1. How did you arrive at a resource base upon which to build a fiscal year 1991 VA medical care budget.

(Response) As detailed in the testimony presented by Paralyzed Veterans of America, (pages 7, 8, 9 and 10) the resource base for the Independent Budget was derived from a projection of the cost of health care services and demand in FY 1991 utilizing the FY 1988 appropriation as the base. A further analysis of the development of these figures which are based on actual veteran need and the projected cost of those services, is included on page 67 and 68 of the Independent Budget which we submit for your review.

A Joint Project of:

AMVETS
4647 Forbes Boulevard
Lanham, Maryland 20706

301/459-9600

DISABLED AMERICAN VETERANS
807 Maine Avenue, S.W.
Washington, D.C. 20024

202/554-3506

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, N.W.
Washington, D C. 20006

202/872-1300

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Avenue, N.E.
Washington, D.C.
202/543-2239

CURRENT SERVICES

During the late spring and summer of 1988, VA began to experience severe funding problems which worsened during FY 1989. The VSOs had anticipated these problems in the last two Independent Budgets and argued for more accurate accounting of current services, to establish more realistic funding. It was clear to the VSOs that additional funding was necessary to support the basic medical care program. Congress had begun to respond to past Independent Budget presentations and to support a more realistic baseline services funding level. However, lack of adequate early supplemental funds for FY 1989 resulted in VA workload reductions at a time when aging veterans required more care.

TABLE 7
Medical Care
Components of Independent
Budget Recommended Appropriation

	(dollars in thousands)
FY 1990	
Current Services Level	$12,094,200
FY 1991	
Payroll Related Increases	
Federal Employee Retirement System	50,000
Annualization of 1990 Pay Raise	50,000
Annualization of 1990 Federal Employee Health Benefit	10,000
Pay Raise 1991	210,000
Within Grade Pay	45,000
Health Benefits 1991	40,000
Inflation	210,000
Facility Activations	275,000
Capital Investment	
Adjustments to 1989 Base	(133,000)
Uncontrollable Workload Changes	
State Home	4,900
Miscellaneous	
Property Rental	3,500
AIDS	60,000
FY 1991	
Current Services Level	12,919,600
Extended Care Program	169,000
Outpatient Workload Increase	165,000
Postgraduate Inservice Training	10,000
Geriatric Training Enhancement	1,500
Equipment	100,000
Decentralized Hospital Computer Program	25,000
Prosthetics and Sensory Aids	4,000
Physician Pay	50,000
FY 1991 RECOMMENDED APPROPRIATIONS	$13,444,100

The Medical Care program is complex and personnel-oriented; more than 60 percent of the Medical Care budget is consumed by personnel costs. If funds are not appropriated to support VA personnel costs, then funds from other discretionary medical care accounts must be utilized. This is the crux of the shortfall problem: For several years, the VA Medical Care program has had to absorb the costs of pay raises, special pay increases and increases in Federal Employees Health Benefits. It also has had to cover the costs of inadequate budgets for new facility activations, and some of the cost of inflation.

In recent years, OMB has annually debited the VA budget 1 percent for assumed increased productivity. Congress has also required that additions to existing health care entitlement and expansions of the health care system (e.g., outpatient clinics) be implemented within the existing appropriation.
It is clear that the VA equipment purchase backlog has become a serious liability to the department. There is evidence that, in some cases, VA is using outmoded equipment, which could delay patient assessment and yield inaccurate results. Although supplemental FY 1989 appropriations were used to purchase equipment, the billion dollar backlog increased from the end of FY 1988 to the beginning of FY 1990.

However, information necessary to propose specific remedies does not exist. The inescapable conclusion is that inadequate equipment funding results in the use of outmoded equipment. VA therefore cannot provide up-to-date medical care in at least some instances, and must compromise quality care in others. We understand that VA has studied its equipment tracking system and is implementing a series of changes, which should allow a more accurate assessment of the backlog.

The environment described above is an invitation to disaster It is apparent that the VA medical care system cannot produce more work without more resources or major changes in the system programs. In fact, in FY 1989, while applications for care increased, hospital, outpatient and especially nursing home care workload decreased, sharply in some instances. VA must clearly identify current services and develop its necessary funding level carefully. Congress must appropriate the funds necessary to support at least the current base of operations. The VSOs contend that a budget for current services should not reflect workload reductions caused by inadequate funding. The current services budget in this document, therefore, maintains baseline services at the FY 1988 level (before significant workload reductions were made). Anything less contributes to further erosion of the

THE INDEPENDENT BUDGET PROJECT

Funding Proposals for Veterans' Programs

2. Why do you remain so critical of the Office of Construction's Facility Development Planning Program (FDPP) when VA asserts it has drastically reduced the number of pages of hard copy involved and kept the cost per FDP at about $250,000.

(Response) The basic problem with the current facility development planning process lies not necessarily with the cost or the number of pages of each FDP. The current process simply will not accomplish what needs to be done with regard to long term facility planning and prioritization of construction needs throughout the system. A further description of the limitations of the FDP process and recommended improvements for the medical care construction program are contained on page 77 and 78 of the Independent Budget.

A Joint Project of:

AMVETS
4647 Forbes Boulevard
Lanham, Maryland 20706

3[illegible]459-9600

DISABLED AMERICAN VETERANS
807 Maine Avenue, S.W.
Washington, D.C. 20024

202/554-3506

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, N.W.
Washington, D.C. 20006

202/872-1300

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Avenue, N.E.
Washington, D.C.
202/543-2239

resource base that is necessary to keep the VA health care system healthy. Appropriate funding must be accomplished within a carefully developed strategic and operations framework for the future VA medical care system.

The FY 1991 Medical Care budget cannot be based on the inadequate FY 1990 appropriation; rather, it must be based on the Independent Budget's FY 1990 current services level of $12.1 billion. This FY 1990 budget baseline was derived by adding the following to the $10.5 billion FY 1989 appropriation:

- shortfall and partial equipment backlog ($820 million).
- payroll items ($440 million).
- inflation ($200 million).
- other uncontrollable costs and adjustments ($94 million).

PAYROLL AND INFLATION

The FY 1991 Medical Care current services determination is developed by making necessary additions as discussed in the following section. Maintaining current staffing levels in FY 1991 will cost an additional $405 million, approximately, for payroll-related increases (see Table 7). The 1991 pay raise is the largest component of this increase. We recommend this pay raise be provided within the FY 1991 initial appropriation to ensure that VA has the needed personnel funds. Current non-payroll items should cost approximately an additional $210 million in FY 1991, because of inflation.

ACTIVATIONS OF FACILITIES

During FY 1991, activations of facilities under construction should require approximately $275 million. The VSOs have difficulty in projecting activation costs because the Administration "embargoes" certain budget-related information before the President's Budget is released. Since essential information involving the completion dates for hundreds of projects is inaccessible, the Independent Budget estimate is based on trends from the last several years of activations.

Officials have told us that the slippage factor -- that is, delay of activations beyond planned dates -- that OMB has used over the last several years has been too high, based on actual VA experience. A more realistic slippage factor, based on the last several years' actual experience, would be more appropriate. Certain capital investment provisions for FY 1990 activations that will not be required in FY 1991 can serve to offset FY 1991 activation costs. This amounts to approximately $133 million.

AIDS: PROGRAM REQUIREMENTS

The VHSRA budget for AIDS does not come close to meeting current workload levels to care for AIDS patients. The VSOs recommend a $60 million increase, which will augment the $40 million in the VSOs' FY 1990 current services budget. (See "Strengthening Medical Care" section, AIDS.)

Combining all the previous adjustments with those listed in Table 7 establishes the current services funding level for Medical Care for FY 1991 at $12.92 billion. It is important to realizethat this increase of $1.6 billion over FY 1990 is required merely to provide the same level of services in FY 1991 as in FY 1988, while correcting serious threats to the quality of care the system delivered in that time frame. This increase exceeds the amount recommended to cover all of our program enhancements shown in the lower portion of Table 7. In other words, the largest portion of the recommended Medical Care budget increase *is not* for program improvements. It is required, rather, to simply preserve a baseline of VA health care activities and ensure the VA system's ability to provide timely, quality health care to entitled veterans.

MOVING TOWARD THE FUTURE

PROGRAM BALANCE AND FLEXIBILITY

The Independent Budget program and workload targets call for extensive use of the least expensive health care delivery modalities, which, based on expert medical opinion, should also provide the high quality care we seek for veterans. Since health care modalities and technology are dynamic, the program mix for meeting veterans' emerging health care needs and the workload/program targets must be balanced yet flexible. Inefficient or duplicative programs should be disbanded or combined with nearby medical center programs where possible. VA standards should be as rigid as -- or more rigid than -- accepted medical practice guidelines, and VA medical management should strictly enforce them. VA should strive to provide efficient, quality care through balanced programs while moving toward tomorrow's targets.

To create program balance and flexibility, VA must consider the service area, determine the workload, reevaluate individual VA medical center missions, and assign programs and activities. Veterans must have access to quality health care. Convenient access is a reasonable expectation -- but not at the expense of quality. VA may find it more cost-beneficial to purchase some types of care than to establish and operate its own programs in those areas where access to a VA medical center may not be reasonable.

be able to demonstrate unique expertise in defining and assessing quality care in such areas as prosthetics, geriatrics, spinal cord injury and rehabilitation.

Still, fully developed outcome statistics -- however complete -- cannot be translated directly into quality measures. Designing valid instruments, determining data needs and testing models' accuracy will take time. We commend VHSRA for taking positive steps with other organizations that will lead hopefully to a valid quality assessment system. The key issue is VA's long-term commitment of resources to maintain data bases and professional staff devoted to their analysis and management. Major private industries invest 3 to 5 percent of their budgets in quality control and assessment programs. To keep pace with this effort, VA needs more resources. It will require a sizeable increase in the number of employees, a much more sophisticated and effective automated data processing network, and an overall budget commensurate with the true health care demands placed on the system.

We urge Congress to request annual progress reports from VA on this very important program. We also will be following, with vested interest, the progress of the four-year on-site contract service reviews of 75 VA medical centers, and resulting recommendations on "how to boost the quality and cost-effectiveness of VA health care services."

ENTITLEMENT TO VA HEALTH CARE SERVICES

The FY 1989 and FY 1990 Independent Budgets proposed that all Category A veterans be granted clear entitlement to outpatient care, and presented the rationale for doing so. Independent Budget authors appreciate Congress's ongoing effort to accomplish this. We are now persuaded, however, that Category A entitlement should include not only hospital and outpatient care, but nursing home care as well. We base this opinion upon the results of redistribution of funds throughout the VA health care system to accommodate budget shortfalls. During the past year, VA has instituted new barriers to access, drastic cuts in community nursing home utilization regardless of need, and VA system workload reductions. These reductions involved absolute denial of access to non-service connected medically indigent Category A veterans -- even where ambulatory medical attention would prevent hospitalization.

IMPROVE MEDICAL CARE CONSTRUCTION PROGRAM

In the past decade, many studies have examined aspects of the VA's construction program, but most of the program's problems persist. These problems include:

- excessive time to complete construction projects, resulting in completed projects that no longer adequately meet users' changing needs.

- seemingly arbitrary selection of construction projects for funding and development. The most urgent needs are not addressed first, and there appears to be no systematic approach to addressing longer-term problems.

- lack of an internal evaluation and improvement mechanism. VHSRA usually addresses systemic problems in the construction process only when they become publicly visible in major projects.

We recommend that criteria based on "what is best for high-quality patient care" guide all design and construction. As stated in the "Revise VA's Health Care System Planning" section, VA must establish clear missions for each VA medical center at the *national* level. Each facility mission will then serve as the proper starting point for planning, design and construction.

A recent Inspector General report on planning also cited this need to establish realistic and appropriate missions: "A decision should be made regarding each facility's future mission and whether facility construction modifications are required to accomplish the plan."

VA must accurately inventory its capital facilities and develop a system for keeping the inventory current. This will enable VHSRA to determine needs from a current information base. Currently, the Five Year Facility Plan, MEDIPP, the Capital Facilities Studies, and the Facility Development Planning Program do not adequately address construction needs, nor have they solved the construction program's time, design, selection and internal correction problems. Therefore, a new approach is necessary -- one that utilizes logical methods for setting national construction priorities.

Once construction priorities are established and a project is funded, a single internal organizational element must account for design and construction management. Current deficiency in this regard was cited in the "Comprehensive Study of the VA's Organization and Procedures for Constructing Health Care Facilities," completed for VA by Booz, Allen and Hamilton and RTKL Associates in April 1985. Managers in this organizational element must be responsible for keeping projects on schedule, by resolving problems *before* they cause delay, confusion and frustration at all levels of VHSRA.

Recommendations

We recognize that all VA construction problems cannot be solved immediately. We believe, however, that VA can initiate improvement by taking the following actions. Specifically, VA should:

o reinforce each VA medical facility's mission and capability to delivery high-quality medical care.

o not spend any more funds on Facility Development Plans until clear realistic missions for each medical facility are understood.

o place a moratorium on funds appropriated for replacement hospitals and major clinical additions until missions for every facility are clear.

o develop a Capital Facilities Inventory which is easy and inexpensive to maintain and update.

o establish a system for setting logical national construction priorities.

o designate a single VA entity to account for construction projects.

HUMAN RESOURCES DEVELOPMENT

Employee Welfare and Morale

We note with satisfaction the successful establishment of VHSRA's Recruitment and Retention Office (RRO). Undoubtedly, the primary challenges the VA health care system faces today are staffing shortages and related problems. The system is becoming less competitive in attracting health care providers from almost every category. While pay scales are inadequate, upgrading the work environment is also of critical importance.

VHSRA recognized this with the RRO's announcement that it will pursue "program activities focusing on shift assignment and rotation, on-site child care, continuing education, nurse governance and autonomy, and support structures for professional staff." To these we would add: professional recognition programs, career counseling, professional growth opportunities, and, finally, more liberal sabbatical leave, where deserved.

Scholarships, tuition reimbursement and periodic subsidized continuing education are not only recruitment and retention tools; they also foster consistency of quality medical care. Educational funds are part of the Medical Administration and Miscellaneous Operating Expense budget account -- a favorite target for OMB cutbacks. These funds must be restored and expanded. Educational programs are further discussed below.

Staffing Shortages

The VSOs recommended in last year's budget proposal that VA physicians' special incentive pay be increased, to stem the expected exodus of doctors starting in October 1990, when retirement income incorporates a percentage of the entire special bonus pay. Starting then, given the incentive of an average additional $6,000 in annual retirement income, as many as 1,000 full-time doctors may leave the system. Among those are 75 chiefs of staff who are eligible for retirement. It is ironic that this retirement provision, originally designed in 1979 to retain physicians, probably will work in reverse, especially because of the last decade's severely compressed VA salaries. The bonus has not been adjusted for inflation since its 1980 inception. There are now wide income discrepancies between federally employed physicians and dentists, those in academia and those in private practice.

These discrepancies have exacerbated VA's difficulties in hiring and keeping well-qualified, full-time physicians. The significant increase in part-time physician employment indicates that physicians are driven to supplement their income through employment service with affiliated medical schools or private practice. The lower VA salaries have led also to increased use of more expensive medical specialty contracts, due to VA medical centers' inability to compete in the hiring of scarce individual medical specialists.

Methods of computing individual bonus pay must also be redesigned. Currently, special pay elements do not emphasize mid-or long-term career commitment. Rewarding years of service more generously will alleviate the current severe VA salary compression. Weight criteria should also give recognition to doctors' proficiency. Currently, in our opinion, VA pays little attention to proficiency in evaluating physicians and dentists. In fact, the practice of awarding equally the competent and incompetent professional mocks the "incentive" intention of special pay.

Finally, local facility directors should have more authority to compute bonuses. They know more about local market competition and can bid more expeditiously. Caps on bonus income should be removed.

Last year, we anticipated that the Congressionally-mandated 1988 quadrennial review of VA special pay would be completed before Congress considered the FY 1990 budget. Although the study has been completed, its submission has been so delayed that there is a question of whether it will even be addressed in the President's FY 1991 budget proposal. Meanwhile, Congress has initiated studies of proposals for military physician and dentist special pay increases ranging from 35 to 48 percent. The value of Department of Defense (DOD) data as a comparison tool is limited, due to the

THE INDEPENDENT BUDGET PROJECT

Funding Proposals for Veterans' Programs

3. You propose expanding entitlement to care for Category A veterans to include outpatient and nursing home care in addition to the current entitlement to inpatient care.

   A. What is your estimate of the annual cost for each of these expansion, separately?

   B. Please provide the assumptions and analysis underlying your estimate.

(Response)

A Joint Project of:

AMVETS
4647 Forbes Boulevard
Lanham, Maryland 20706

301/459-9600

DISABLED AMERICAN VETERANS
807 Maine Avenue, S.W.
Washington, D.C. 20024

202/554-3586

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, N.W.
Washington, D.C. 20006

202/872-1300

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Avenue, N.E.
Washington, D.C.
202/543-2239

2/28/90

The Cost and Workload Implications of Expanding Category A Entitlement to all VA Medical Care Programs

The implications of expanded entitlement for Category A veterans from a workload and cost perspective are outlined below.

OUTPATIENT CARE - Workload and Costs

The estimates presented below are derived basically by age group based on the use patterns of veterans in the current environment.

Age 65 and over -
Applying current use rates for Category A veterans to the projected 1995 veteran population yields an increase to 9.3 million visits. Patterns of use in this age group of the veteran population are not likely to change drastically because of the current existence of multiple entitlement to health care, especially Medicare and Medicaid. Thus, there is no expectation of increased use of the VA system from this entitlement change except for the increased number of veterans falling into this age group.

Under age 65 -
Applying current use rates to the projected Category A population in 1995 yields 8.8 million visits. At 8 visits per user per year this indicates approximately 1.1 million expected less than age 65 users under current entitlement - 15.5% of all Category A veterans under age 65.

The 1987 survey of veterans estimates that 22% of the Category A population under age 65 are uninsured. Assuming that the vast majority of current users are also uninsured then increasing the user population to include all the uninsured should capture the majority of expected users of VA outpatient care under expanded entitlement. Since 22% of Category A veterans are entirely uninsured, this implies a 42% increase in the Category A user population, or an expected 1.6 million users in FY 1995. At an average of 8 visits per user per year, the expected number of visits for this group would be 12.8 million/year.

To summarize outpatient workload estimated with expanded entitlement for FY 1995:

	Estimated Number of Visits
Age 65 and older	9.3 million
under 65	12.8 million
All other visits (Cat. B, C, non-vets, unclassified, etc.)*	3.6 million
Total for FY 1995	25.7 million visits

*There are 1.3 million visits made by non-veterans, a large number of which are VA employees and some additional visits through sharing with the military. There are also 1.2 million visits that are uncoded or unclassified as to category of veteran in this group in 1988. The visits for this group have been held constant.

Expected outpatient workload for FY 1995 in the absence of full Category A entitlement as shown in the Independent Budget for FY 1991 is 24 million visits. The expected increase in FY 1995 attributable to full Category A entitlement would be 1.7 million visits more than would be expected under current entitlement. At the current rate of $100/visit this would amount to and additional cost $170 million over Independent Budget planned workload without offset considerations.

Comparing the Independent Budget estimates, for the President's Budget and expanded Category A entitlement for FY 1991 results in the following for outpatient workload:

Expanded Category A entitlement FY 1991	24.0 million visits
FY 1991 planned outpatient visits Presidents Budget	21.8 million visits
Difference	+2.2 million visits

The following cost offsets are based on estimates of savings that could be realized from Category A entitlement to outpatient care.

1) Patient days of care due to conservative partial reductions in inpatient workload for 1 and 2 days lengths of stay = 194,000. At an average cost of $350/day - savings per year $68 million.

2) Reductions in all other inpatient days of care attributable to inappropriate hospitalization, better control of health care through follow-up in outpatient care - 5% of remainder of discharges or 200,000 patient days of care at $350 savings per year $70 million.

Other initiatives that are recommended to be coupled with the expanded entitlement are:

1) Collect and retain reimbursements (including third party reimbursements) to offset outpatient visits made by employees, non-veterans, etc. 1.3 million visits at $100 per visit = savings per year $130 million.

2) set aside unstaffed beds in each facility for sleeping quarters for veterans who must travel long distances for clinic visits or hospital stays. This may eliminate unnecessary hospitalization for patients who need some service that can be adequately provided on an outpatient basis, especially in rural areas. House keeping staff could care for these sleeping quarters and stays could be limited to one day.

3) Reduce hospital length of stay by converting unused hospital beds to nursing home care for use in assuring appropriate patient levels of care. Uncalculated savings of considerable magnitude could result.

4) The FY 1991 Independent Budget calls for an increase of $165 million to meet increasing costs associated with anticipated growth in outpatient care requirements. If such funding were to be made available, as recommended the costs for this program, to the extent they would exceed this amount, would be substantially met.

From this assessment, it appears that there is the potential to more than offset the costs of increased workload associated with the estimated increases in workload associated with outpatient entitlement for Category A veterans.

NURSING HOME CARE

Nursing home care estimates of ADC are based on the 1985 National Nursing Home Survey conducted by the National Center for Health Statistics. Using those data with the Category A veteran population, it is estimated that 100,000 Category A veterans (VA sponsored and non-VA sponsored) will require nursing home care on any given day in 1995. In 1990, the Independent Budget projected VA sponsored nursing home ADC is 38,200 - 96% of this census, or 36,700, are Category A veterans. The expected ADC for all Category A veterans for 1990 is 79,000 resulting in a Category A VA sponsor nursing home program participation rate of 46%.

Applying this 46% participation rate to the FY 1995 estimated total Category A ADC of 100,000 (using National Nursing Home Survey data with projected 1995 veterans population in Category A) results in

a VA sponsored ADC of 46,000. Increasing the VA participation rate by 10% as a result of a Category A entitlement yields an ADC of 50,000 for Category A in 1995.

The 10% increase in the participation rate is considered to be a maximum. Savings in this program can be realized through more aggressive case management.

Cost Considerations for Nursing Home Care

The Independent Budget projected a VA ADC of 47,000 for FY 1995 to be supported by appropriations. As a consequence, in the context of VA budget requirements from the Independent Budget perspective, no change in cost estimates would be indicated. Also, the Independent Budget anticipates an annual growth toward the 1995 target. If, however, the full Category A entitlement were to become a reality before 1995 an increase in workload will occur sooner than anticipated by the Independent Budget. With a planned increase in the budget for nursing home care of $100 million/year the workload could be accommodated in 1995 as projected. Some of this cost could be offset by more appropriate placement of current hospital inpatients.

The Independent Budget has assumed the increased costs of providing health care over time and had those recommendaticns been followed in FY 1988-1990 the costs of these proposed programs would have been partially assumed in the current funding base. The implementation of the program outlined should be coupled with cost saving initiatives suggested in the above discussion.

THE INDEPENDENT BUDGET PROJECT

Funding Proposals for Veterans' Programs

4.. Regarding table 13 in the Independent Budget, there are five proposed additions to the fiscal year 1991 budget that were not accompanied by detailed justification. For each of these -- AIDS related training, health manpower training grant program, associate degree program, health professional scholarship program, and management training -- please provide the Committee with written justification, including comparisons with the President's budget request.

The VA resource need for Acquired Immune Deficiency Syndrome and Hepatitis B is discussed in some detail on pages; 68, 80, 83 and 84 of the Independent Budget document as follows:

Infectious Disease Prevention

VHSRA has designed a multi-phase program to train HIV and HBV prevention counselors and VA health care providers including interdisciplinary teams; to conduct AIDS education activities; and to support AIDS research fellowships. We recommend a $3 million appropriation to fund AIDS-related training programs.

Acquired Immune Deficiency Syndrome

Two years agc (FY 1988), VA's AIDS and AIDS Related Complex (ARC) caseload was approximately 7,000. Roughly 50 percent of these patients were carried over from previous years. This represents about 7 percent of the Nation's 104,000 Aids and ARC cases.

Since FY 1988, therapy and the prescription of AZT to all HIV positive individuals, to suppress disease symptom onset, have resulted in greater longevity. At the same time, VA's costs for AZT have decreased from $8,000 to $6,500 per patient per year.

Together, these factors should increase future patient volume and cost. VHSRA now expects 4,260 new inpatients in FY 1991, and 3,300 readmissions from previous years. In addition, VA will follow 7,500 outpatients.

A Joint Project of:

AMVETS
4647 Forbes Boulevard
Lanham, Maryland 20706

301/459-9600

DISABLED AMERICAN VETERANS
807 Maine Avenue, S.W.
Washington, D.C. 20024

202/554-3506

PARALYZED VETERANS OF AMERICA
801 Eighteenth Street, N.W.
Washington, D.C. 20006

202/872-1300

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
200 Maryland Avenue, N.E.
Washington, D.C.
202/543-2239

The average implied hospital stay is 30 days, at an average daily cost of more than $700. depending upon the severity of illness. For example, the treatment costs for patients with the pulmonary complication pneumocystis carnii (PCC) may be two or three times higher than average. Outpatient visits cost between $111 and $160. VA's data on AZT expense alone is not available, but a conservative estimate for FY 1991 would be $60 million. Other expensive antiretroviral agents are in development. Together these costs justify a conservative requirement of some $220 million in FY 1991 just for AIDS and ARC treatment. This contrasts with the expected $127.6 million required for the current fiscal year.

In 1989, the U.S. Public Health Service predicted that there would be 450,000 or more AIDS and ARC cases in the United States by 1992, and that 280,000 of these cases would have died. Now, with increased longevity, the latter number is reduced. If VA continues to see a 7 percent share, it will be responsible for more than twice its projected 1991 volume. Treatment probably will be essentially the same as today, and, most likely, there will not yet be a vaccine.

The FY 1990 VHSRA budget specifies $32 million for AIDS treatment. This covers but a fraction of the expected demand. We wish to underscore once more the need to provide additional funds to meet the high cost of this growing epidemic. Previously budgeted medical care funding for other patient care cannot absorb the very substantial VA expense for treating AIDS and ARC patients.

The Independent Budget's FY 1990 current services level includes $40 million for AIDs. We therefore recommend no less than a $60 million increment in the FY 1991 Medical Care Appropriation for the treatment of AIDS and ARC. (See "Specific Recommendations. Current Services" on page 68.)

Hepatitis B: Risk Avoidance

Commonly associated with the risk of exposure to the AIDS virus (HIV) is that of type B infectious hepatitis (HBV). Previously known as serum hepatitis. HBV is a viral infection that can cause acute and chronic disease. Symptoms can range from flu-like illness to a more severe clinical illness characterized by jaundice, nausea, vomiting, loss of appetite, abdominal pain and diarrhea. Chronic infections presents frequent period of illness and continual, usually life-long infectious status. In the most extreme cases, death can result from fulminant hepatitis, viral cirrhosis or liver cancer.

When an individual is infectious, either because of acute infection or as a carrier, his or her blood and certain body fluids can transmit the virus to others. HBV is more easily transmitted than HIV.

The Center for Disease Control (CDC) estimates that 30 to 40 percent of U.S. high-risk health care workers have already been vaccinated. High risk groups include laboratory technologists, operating room staff, nursing personnel, surgeons and pathologists. CDC also estimates that 30 percent of the nation's at-risk population is immune to HBV because of prior infection that has not yet symptomatically manifested itself.

Since 1987, two new HB vaccines have been developed and licensed for use in the United States. Extensive evaluation demonstrates their safety and high percentage of efficacy (85 to 97 percent, and lasting at least seven years). Also available is a dependable laboratory test for the HBsAG antigen, which indicates an individual's HBV infection and carrier status.

The Occupational Safety and Health Administration (OSHA) has published its intent to promulgate regulation management standards for high risk health care workers. OSHA hearings are underway. Meanwhile, guidelines are available for voluntary compliance, specifically with use of the HBV vaccine. DOD's programs include screening, immunization, and other environmental control techniques. Immunization is provided to health care personnel, and troops deployed to areas where HBV is prevalent.

VA has discontinued Central Office control of this program. The vaccine is now available at most facilities, but is not used often because of high cost and budget austerity. This is regrettable, if not intolerable. If VA is to provide quality care, it must utilize modern therapy.

Previous vaccine cost of up to $300 for series of doses has recently decreased by more than 50 percent due to pharmaceutical competition. HB vaccines are given in three doses over a six-month period. Pre-vaccination and post-vaccination testing for the antibody may be considered. A blanket immunization program for health care workers may involve up to 50,000 personnel.

The Independent Budget authors recommend that Congress urge VA to implement a universal HBV risk management program and earmark $5 million for this purpose.

HPSP Program

Of the educational programs referenced in the above question, only the Health Professional Scholarship Program is specifically mentioned in the President's FY 1991 Budget for which an increased appropriation of $1.7 million is requested.

The Independent Budget proposal differs in that we recommend the HPSP program also be used as a recruitment tool for VA physicians in a manner so successfully utilized by the Army, Navy and Air Force medical services. Page 79 of the Independent Budget document details this proposal as follows.

"We support H.R. 3199 (cited as the "Veterans Health Professionals Education Amendments of 1989") which links the Montgomery G.I. Bill to the Health Professions Scholarship Program (HPSP). This is consistent with our FY 1990 proposal for VA-sponsored medical school scholarship appropriations. The HPSP has long provided the military medical services with most of their new physicians. We note, parenthetically, that the HPSP medical school program under the Department of Health and Human Services (DHHS) auspices was discontinued in 1988, no doubt because of past predictions of a coming excess of U.S. physicians. That prediction may no longer be valid. More physicians appear to enter corporate structures on a salary basis for shorter work weeks. More female physicians devote fewer hours to their profession. A reduction in resident staff work hours is expected. Physicians are involved increasingly in administration and non-traditional clinical activities. Physician-labor intensive technology has accelerated. The aging citizenry and the AIDS epidemic have increased the need for heath care. Finally, there are fewer medical school applicants."

Health Manpower Training Act

The rationale for supporting the Cranston proposal for reinstatement of the Health Manpower Training Act is detailed on page 80 of the Independent Budget as follows:

Re-inactment of the Health Manpower Grant

The Senate originated and passed this legislation. This program, which awaits House action, would provide awards to health manpower training institutions affiliated with VA medical centers. Its intent is to increase training capacity for fifteen allied health profession disciplines which face shortages.

VA nursing shortages persist despite VA's investment of more than $150 million in special salary rates to compete for nurses in local labor markets. (These payments now average $65 million per year at 138 of the 172 VA medical facilities). Many urban VA facilities report vacancy rates as high as 25 to 30 percent. It is now clear that the department cannot successfully compete with the private sector for these scarce personnel without more funds for salaries. Both the House and Senate Veterans Affairs Committees have a continuing interest in improving the VA nurse pay system. The House has enacted H.R. 1199, and the Senate S. 13 which emphasize allowing local hospital directors the flexibility to meet local demand in nurse recruitment and retention costs. The Independent Budget authors strongly support these proposal, pay scales and features.

The companion shortage of specialty therapists and technicians, both in the VA system and the private sector, is equally distressing. These shortages jeopardize VA's capacity for rehabilitation therapy and prosthetic services, especially. For this reason, the VSO sponsors of the Independent Budget also support, as we did last year, legislative proposals to reinstate the Health Manpower Training Act, which would expand the capacity of health profession schools affiliated with VA medical centers to increase the number of students who pursue training in VA staff 'shortage areas.'"

The Associate Degree Program

A description of our recommendation for this program appears on page 80 of the Independent Budget.

Increased Funding for In-house Associate Degree Program

"Last year's Independent Budget also recommended this increase. Limited to candidates already under VA employ, the program draws potential registered nurses and allied health personnel from within VA ranks. Young, low-salaried, deserving candidates are selected to pursue associate degree education. This differs from the ongoing Tuition Reimbursement Program for limited subsidy of part-time schooling. Candidates receive VA salaries for part-time employment during the two-year curriculum, and reimbursement for tuition, books and related fees. This requires two years of VA service for each year of academic support. We recommend an additional $5 million funding for this program."

Management Training for Clinicians

A description of our recommendations for this program appear on page 80 of the independent Budget as follows:

"VHSRA has already initiated this training, but it deserves additional funding. It consists of two programs - one for new chiefs of staff and one for clinical service chiefs -that develop these individual and group managerial skills. VA physicians and other clinical care providers who assume managerial roles face challenges that are fundamentally different than their clinical duties. Yet few have had any training for these responsibilities, as recent needs assessments show. We request incremental funding of $500,000 for this purpose, which will provide training for approximately 40 chiefs of staff and 100 clinical service chiefs each year. Turnover in these positions, which is expected to increase, creates unusual need for this training."

University
of Nebraska
Medical Center

College of Medicine

Office of the Dean
42nd and Dewey Avenue
Omaha, NE 68105-1065
(402) 559-4204
FAX (402) 559-4148

April 18, 1990

Senator Alan Cranston
Chairman, Committee on
 Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Cranston:

Please excuse my delay in responding to your request for more information regarding my testimony on February 23, 1990. Regarding your question about which types of physicians would the VA lose first with a decrease in funding of meritorious research proposals, I believe junior faculty, i.e., assistant professors, would be the most likely to leave. With respect to specialty, it is likely that those in the medical specialties would leave first, because they would either go into practice, or return to the medical school, and probably spend more time in direct patient care, with its resultant generation of more professional fees. This would be a way of showing productivity since they would feel thwarted in their attempts to be productive by conducting research.

VA and NIH research programs have separate and distinct focuses that are complimentary, but not interchangeable. In general, the NIH sponsors basic, undifferentiated research, much of it conducted at the molecular level. In fact, the NIH identifies itself as non-clinically focused. Unlike NIH, VA research is largely clinically-based.

VA research could be described as further along the continuum in the application of science. As such, VA-sponsored research relates more directly to patient care than does NIH. Additionally, projects funded by the VA are primarily centered on diagnostic areas that correlate to the health care needs of veterans. In general, NIH is less concerned about immediate applicability of research to patient care. Thus, these two federal research programs fit well together and benefit from the focus of the other, but neither program duplicates nor could replace the efforts of the other.

Of equal importance, the VA research program plays an invaluable role in recruitment and retention, as well as quality assurance. Given these factors, the effects of research budget cuts could not be mitigated by other sources of research support.

NIH does not have sufficient resources to compensate for reductions in the VA research program. The NIH budget grew moderately during the mid-80's, even after adjusting for inflation. NIH has done less well in recent years, particularly in FY-1990 when NIH's appropriation level barely met inflation.

For FY-1991, the Administration requested a 4.7 percent increase in real dollars. If funding earmarked for initiatives related to AIDS and the human genome project were subtracted, remaining NIH programs would realize an increase of only 3.7 percent, less than the Administration's designated 4.2 percent inflationary factor.

NIH funding has more than doubled since 1982, yet at the same time, the system has faced considerable strain related to increases in the cost of grants. A variety of factors are involved in increasing cost, including the increasing number of non-competing research project grants as well as a lengthening of the average period for research project grants. A policy decision by NIH has resulted in fewer competitive grants awarded on an annual basis. In addition, all NIH grants must undergo reduction from scientifically based study section recommended levels due to funding constraints. Given the pressure on NIH to manage their own funding requests, it is unrealistic to assume that NIH could support deficiencies in VA research funding.

Thank you for the opportunity to expand on my testimony and, once again, please excuse my delay.

Sincerely,

Robert H. Waldman, M.D.
Dean

RHW/jm

WRITTEN QUESTIONS FROM SENATOR COHEN TO THE DEPARTMENT OF VETERANS AFFAIRS AND THE RESPONSES

Other Options Recommended

Question: According to Department documents, "The task force recommended a number of consolidation options ...." What were the other options recommended? What were the pros and cons of each option and the specific reasons each of the unselected options was rejected?

Answer: The following options were offered for consideration:

Option A. The first option is to maintain the status quo. The problems detailed above which are faced by the region's stations do not support continuation of the current structure. It is inefficient and costly. The stations currently are faced with minimal staffing and, overall, an expected high attrition rate. There are problems in recruiting and retaining qualified staff at several of the locations. While program expertise at the stations is currently at an acceptable level, the Task Force believes that, as losses occur, the program in the region could be at risk, even though those who will remain will work hard and do well. The number of types of tasks to be completed may become overwhelming with the result that backlogs will rise and timeliness deteriorate. Stations are currently conducting a significant amount of cross-training to fill existing and potential gaps. It is the consensus of the Task Force that this will not meet their needs two years from now.

Option B. The second option considered was to locate individual functions at each of the stations which currently have a Loan Guaranty Division. The positive and negative aspects of this option are same as those of Option A. This option would have created administrative and cost burdens which would have been virtually impossible to surmount.

Option C. The third option the Task Force then looked at was combining some Loan Guaranty activities at one location. All combinations were reviewed. The final combination selected was to combine Loan Processing (LP) and Loan Service and Claims (LS&C) with appropriate Construction and Valuation (C&V) and Property Management (PM) presences in the field. The Task Force initially felt that these two program elements were the most conducive to consolidation. The added advantage would be the retention of expertise at the field stations, in the current configuration, to deal with the public, vendors, and the field station personnel themselves. Combining LP and LS&C was thought to be a cost saving step which would improve service by having these functions at one location. Some efficiency and effectiveness through economy of scale would be achieved.

Option D. The fourth option considered was an administrative consolidation of all New England Loan Guaranty functions under one division. This option would leave all existing Loan Guaranty staff where they are currently located with the exception of the Office of the Chief. This function would be centralized and would result in a potential RIF and/or translocation of personnel currently serving as Loan Guaranty Officers and Secretaries. It must be recognized that Division Chiefs and secretaries, if assigned, perform a wide variety of tasks: clerical, technical, and managerial. Consequently, staffing levels may need to be revised to ensure that there is sufficient appropriately graded staffing to perform all tasks. Remaining personnel would continue to be based at their present duty stations although they would administratively report to the (centralized) Loan Guaranty Officer, becoming a "tenant" activity at their (former) parent station. Short-term personnel needs could be handled through detailing individuals from one duty site to another (with accompanying travel/per diem expenses), while long-term needs caused by turnover would result in the abolition of the position at the out-based location and its re-creation at the primary site. This would result in a very gradual centralization of the activities at one site while minimizing the impact on current employees. Although the administrative burdens would be large and operational costs might increase temporarily, the end result, over a 4-5 year period, would be a centralized operation. There would be the added plus that the gradual nature of this option would allow for a greater degree of flexibility should situations change.

Option E. The fifth option considered was to combine the options of merging Loan Processing and Loan Servicing and Claims with the administrative consolidation at one site. The Task Force felt that this option provided an intermediate course of action between an administrative consolidation and moving immediately to the single division concept. This option integrates the savings from the economies of scale provided by joining the two functions with the benefits to be realized in an administrative consolidation, both in terms of financial savings and a unified management approach in the region.

Option F. The sixth option considered was a complete consolidation of all Loan Guaranty activities at one site. A residual amount of expertise would be left at each of the stations currently with Loan Guaranty Divisions. This expertise would be in the Veterans Services Divisions where it would be expected that they would pick up additional Loan Guaranty work. They would be responsible for handling all walk-in traffic for Certificates of Eligibility and other status inquiries. Although some resistance from those divisions is possible, the expected gains to be made would offset any difficulties that would be experienced.

Reason for Selection:

The Task Force recommended a Loan Guaranty program realignment which encompassed the entire New England region. An examination of the region's workload, productivity, staffing, and expected attrition supported the need to realign in order to conserve the existing program expertise and maintain acceptable quality and timeliness levels of benefits and services delivery. The Task Force also indicated the need to complete realignment action within 18 to 24 months to avoid further jeopardizing the program's integrity throughout the region.

The Task Force offered the six options discussed on the previous pages. After a review of the Task Force report, we determined that options A, B, C, D, & E would create unnecessary communication, administrative, and managerial problems. These other options were rejected because they would be only short-term stop-gap measures which would merely delay the inevitable need for total consolidation (provided for in option F). Option F (Total Consolidation) was selected as the only viable method of maintaining the integrity of the Loan Guaranty program in the New England area.

Consolidation of New England Loan Guaranty Operations

Standards of Service

Question: Department documents state that the "VBA task force was convened ... to find ways to improve the efficiency and effectiveness of Loan Guaranty operations in New England," which apparently are measured in terms of productivity levels based on workload and FTEE. These documents also state that "All activities related to the consolidations will be secondary to maintaining our high standards of service ...." What are these standards of service -- i.e., how does the Department measure service for the various activities of a loan guaranty office?

Answer: The Department has established national timeliness and accuracy and compliance standards for 18 major end products such as appraisal for loan origination, processing specially adapted housing, determinations of eligibility, guaranty issued, supplemental servicing of a guaranteed loan, and property sold-offer accepted. The standards are based on the concept of minimally acceptable levels of performance. For accuracy and compliance, a minimally acceptable performance level is expressed as a maximum acceptable error or defect rate. For timeliness, it is expressed as a minimum percentage of cases expected to be processed within a stated number of calendar days.

The primary purpose of these quality control standards is to cause a high level of quality of services and end products to be achieved. The standards also produce an indication of the quality of operations nationwide and at individual field stations.

Each Regional Office performs monthly quality and timeliness reviews based on a random sampling of end products to measure service for the various activities of loan guaranty. VBA collects this data quarterly to determine Loan Guaranty performance. This data is also used when VA Central Office conducts a survey (compliance review) of the individual station. During the survey process, the VACO Quality Control Staff performs its own sampling of end products for each quality criteria for a comparison with station quality control review findings.

Question: How do each of the New England loan guaranty operations rate in terms of these standards of service, including the standards used to measure quality and timeliness?

Answer: For the 12 month period ending September 30, 1989, the four New England Loan Guaranty Divisions met quality standards (their error rates were above minimally acceptable levels) except in the following areas:

BOSTON: Specially Adapted Housing and Initial Property Analyses

MANCHESTER: Liquidation Appraisals, Initial Property Analyses, and Property Repaired

For the 12 month period ending September 30, 1989, the four New England Loan Guaranty Divisions met timeliness standards (cases were processed within acceptable number of days) except in the following areas:

BOSTON: Liquidation Appraisals, Specially Adapted Housing, Guaranty Issued, Request for Release of Liability, and Servicing and Liquidation of GI Loans

HARTFORD: Specially Adapted Housing

MANCHESTER: Reconsideration of Value, Liquidation Appraisals, Servicing and Liquidation of GI Loans

TOGUS: Reconsideration of Value, Specially Adapted Housing, Request for Release of Liability

It should be noted that we do not consider these quality findings to be serious. Generally these are technical and procedural errors and do not necessarily indicate that service to veterans or program management is lacking.

Question: What are the projected standards of service for the proposed consolidated LGO at Manchester?

Answer: Since the standards for accuracy/compliance and timeliness are national standards, the existing standards will apply to the consolidated Loan Guaranty Division at Manchester.

White River Junction LGO

Question: In 1984, the loan guaranty operation at White River Junction was transferred to Manchester. What were the workloads and staffing for the White River Junction LGO in its final two years of operation?

Answer: In 1982, the paid FTE was 3.3. In 1983, the paid FTE was 3.0.

Question: How do the loan guaranty services presently provided to Vermont veterans compare to those that had been provided by the White River Junction LGO? (Please provide a quantitative response.)

Answer: The following is a comparison of workloads for 1982/1983 with 1988/1989:

CRV's	FY 1982	FY 1983	FY 1988	FY 1989
Existing	151	265	74	124
Proposed	7	19	9	9
Loans Closed	94	185	52	87
Defaults Reported	41	38	31	31
Claims Vouchered	9	9	4	3
Properties Acq'd	12	12	4	2
Properties Disp'd	6	16	5	5

Togus More Service/Property Management Oriented

Question: The Department's "Detailed Plan and Justification: Transfer of LGO, Togus" states that "Since most of the Loan Guaranty workload in New England is related to loan origination, employees perform servicing and property disposition functions infrequently. When work is not performed regularly, poor quality and failure to meet timeliness standards often result."

1.) Isn't it true that Togus performs far more servicing and property disposition than the other New England loan guaranty offices ? (According to Department data, as of last fall, Togus had 2928 Loan Service and Claims cases compared to 1828 for Boston, 633 for Hartford, and 15e4 for Manchester. For Property Management, Togus had 58 cases, compared to 2 for Boston, 5 for Hartford, and 11 for Manchester.)

Answer: Yes, Togus's servicing and property acquisition/ disposition workloads are heavier than the other three Loan Guaranty Divisions in New England. In FY 1989, Hartford sold 4 properties, Togus sold 16, Boston sold 3, and Manchester sold 2.

Question: 2.) How does Togus compare to the other New England offices and the proposed consolidated LGO (based on Department projections) in terms of quality and timeliness and other measures of service for servicing and property management?

Answer: Togus's service is good and compares favorably with the national averages. We project that service from the proposed Manchester consolidated Loan Guaranty Division will be as good or better and will result in a cost savings over the long run.

Question: 3.) Isn't it true that Department data indicates that Togus's present productivity levels for Property Management and Loan Service & Claims are either higher than or very near to that projected for a consolidated LGO at Manchester?

Answer: It is true, the productivity figures for Togus are higher than what is projected for the consolidated office at Manchester. However, higher productivity by itself does not mean that Togus is performing better or that the relationship between employment and workload is in balance. The productivity index for the Property Management function was 179.3 in FY 1989. Productivity levels above 120 percent are excessively high and usually indicate that there is insufficient staffing for the workload. However, a closer look at the data revels that Togus devoted about one third of a staff year (.3 FTEE) to property management functions. This coupled with higher than anticipated workload yields the excessive productivity figure. This situation highlights the problem with managing very small Loan Guaranty Divisions (i.e., it is difficult to allocate resources to changing workloads). Larger stations can staff their divisions so that employees work full time in a specific function. Management can then shift personnel within the division as workloads vary due to seasonal or economic changes.

Question: 4.) The Justification report indicates that a major concern is that "any negative shift in the New England economy or real estate market leading to loan terminations and property acquisitions could have a negative impact on loan guaranty operations." Isn't that concern far less valid for Togus than the other New England offices, since Togus does far more servicing and property management than the other offices, including 74% of all of the Department's New England property management? Might, in fact, the Department's ability to respond to an unfavorable turn in the Maine economy or real estate market be harmed by moving the Togus LGO to Manchester?

Answer: Togus certainly has more experience with loan terminations and property acquisitions than the other New England Offices; however, should the workloads double or triple as they have in other offices due to economic downturns, Togus would not be staffed to handle them. A consolidated site, adequately staffed with trained personnel dedicated to certain functions, would be far better equipped to deal with the increased workloads.

Question: 5.) How important are knowledge of the local market and site visits in properly managing cases involving loan terminations and property acquisitions?

Answer: The VA has always relied on private sector appraisers and management brokers to conduct appraisals on foreclosures and property inspections prior to selling an acquired property. The consolidated Manchester office would continue to utilize the services of these local experts. In addition, we believe VA personnel working at the office would quickly gain the market knowledge needed to review the work of these appraisers and management brokers. This has been our experience at other regional offices with responsibilities for more than one State and/or large geographic areas.

Eligibility Certificate Processing

Question: According to the Maine Association of Realtors, the Togus LGO currently processes Eligibility Certificates on a same-day basis. Will this be the case for the proposed consolidated LGO?

Answer: The proposed consolidated Loan Guaranty Division will be able to process walk-in/walk-out requests for Certificates of Eligibility on a same-day basis. In addition, veterans will still be able to obtain certificates of eligibility in most cases from the Veterans Services Division at the VAM&ROC in Togus.

FHA Consolidation Experience

Question: Several years ago, the FHA transferred its office in Bangor, Maine, to Manchester. This resulted in extensive delays for loan approvals. Sixty-day contracts often expired due to the inability of the consolidated office to handle the increased workload and the resulting increased costs were passed to consumers. In light of the disastrous results of its consolidation experiment, the FHA reopened its Bangor office.

Did the VBA task force or the Loan Guaranty Service review the FHA's experience in transferring operations from Maine to New Hampshire?

Answer: Neither the task force nor Loan Guaranty Service reviewed the FHA experience in Maine. There were and are significant differences in VA and FHA loan processing procedures and, in our view, a comparison between the two is not practical. The Loan Guaranty Program has had past experience in consolidations. Several jurisdictions are served by Loan Guaranty divisions in neighboring regional offices: Rhode Island is served by Boston; Vermont by Manchester; Delaware by Philadelphia; North and South Dakota by St. Paul; Nevada by San Francisco and Los Angeles; and Wyoming by Denver. Our experience in those areas has been positive. We have been able to provide services to veterans efficiently and more cost effectively than if there was a separate office for each State.

WRITTEN QUESTIONS FROM SENATOR MITCHELL TO THE DEPARTMENT OF VETERANS AFFAIRS AND THE RESPONSES

Non-section 210(b)(2) Offices

Of the four loan guaranty divisions (Togus, Manchester, Boston, and Hartford) that VA is proposing merging into a single Manchester regional office, only Togus falls under the "notice and wait" provisions of section 210(b)(2), Title 38, U.S.C.

1a. Are the Boston and Hartford office consolidations contingent on VA securing authority to consolidate Togus into Manchester?

ANSWER: No, the consolidation of Boston and Hartford into Manchester is not contingent upon Togus.

1b. If not, when will those offices be consolidated into Manchester?

ANSWER: The Boston and Hartford Loan Guaranty operations will be consolidated into the Manchester VA Regional Office June 1, 1990.

Public Outreach

When first notified of the VA's consolidation plans, I was told VA planned to outline its plan to realtors and lenders. However, many of the organizations have told my office VA had taken no steps to apprise them of the proposed consolidation.

2. Please provide documentation of the VA's outreach efforts, including copies of correspondence, press releases, and meeting and seminar announcements.

ANSWER: Attached are copies of Loan Guaranty Release 89-18, a News Release, and a Report of Contact by the Public Information Officer at the Togus VAM&ROC.

Personnel Levels

The proposed consolidation calls for 22 FTE in the first year. According to the plan and justification employment in the consolidated office will drop from 22 to 20 FTE in two years.

3a. The executive summary of the New England Directors Task Force, proposed 27 FTE. Why was the recommended personnel levels reduced by CO in its final proposal?

ANSWER: The personnel levels were reduced by CO after an analysis of FY 1986 over FY 1987 workloads. Based on Loan Guaranty's work measurement system, the combined workloads in New England supported a staff of only 22.

Where were the reductions made from the Task Force's recommended levels?

ANSWER: The FTE reductions from the Task Force recommended levels were 3 technical positions and 2 clerical positions.

3b. Will a FTE level of 22 at the proposed consolidated office provide optimum productivity?

Based on the FY 1988 workloads accomplished and the workloads projected for FY 1989, 22 FTE would have provided optimum productivity. However, the FTE has now been increased to 26 FTE based on increased workload in FY 1989.

3c. In his appearance before the Committee, Henry W. Gresham, Director of the Manchester VARO, indicated that the consolidated regional office FTE level has been revised to 26 positions. Is that the case?

ANSWER: Yes, the FTE has been increased to 26 FTE based on an analysis of workloads accomplished during FY 1989. The number of FTE is based on Loan Guaranty's work measurement system.

If so, where would the additional three staff positions be allocated?

ANSWER: A proposed organizational plan has been developed showing an increase in three technical positions (1 staff appraiser and 2 loan specialists). However, the consolidated office at Manchester will have some flexibility in deciding their final organizational structure. A copy of the proposed organization plan for New England is attached.

3d. Where will the two FTE come from?

ANSWER: The increased FTE of three will come from ceiling assigned by the Veterans Benefits Administration to Manchester.

What effect might that have on the office ability to provide service to veterans?

ANSWER: The increased FTE should assure that the New England consolidated office has optimum staffing to provide the services and benefits that veterans and program participants have come to expect from the four New England Loan Guaranty Divisions.

What effect will the personnel reduction have on the office's productivity?

ANSWER: We anticipate that the increase (not reduction) in personnel will effect a better balance between staffing and workload and that the productivity for the consolidated office will be nearer the national average.

If the consolidated office is to have 25 FTE in the coming year, would the out-years employment levels reflect this increased staffing?

ANSWER: The consolidated office would not necessarily have 25 FTE in the out-years. Their staffing would be based on workload and budgetary constraints.

3e. The plan and justification says that "routine and continuing training of Veterans Benefits Counselors will be planned and carried out by the consolidated loan guaranty division". Which of the 22 FTE in the loan guaranty division will plan and carry out the training?

ANSWER: Generally, training is planned by management (Loan Guaranty Officer, Assistant Loan Guaranty Officer, or section chiefs). Management could conduct the training. They could also delegate training to technical or even clerical employees who have expertise in the subject and the communication skills to conduct the training.

FHA/HUD Experience

In opposing the consolidation, almost all of the industry groups have referred to the experiences suffered when the Maine FHA/HUD office was consolidated to Manchester in 1986. The principal complaints associated with that consolidation were significant delays in loan request processing and a lack of specialized knowledge about the Maine market.

4a. Was the FHA/HUD experience considered by either the Regional Directors Task Force or CO prior to recommending this consolidation?

ANSWER: Neither the task force nor Loan Guaranty Service reviewed the FHA experience in Maine.

4b. If not, would the VA do so before proceeding with the proposed consolidation?

ANSWER: There were and are significant differences in VA and FHA loan processing procedures and, in our view, a comparison between the two is not practical. The Loan Guaranty Program has had past experience in consolidations. Several jurisdictions are served by Loan Guaranty divisions in neighboring regional offices: Rhode Island is served by Boston; Vermont is serviced by Manchester; Delaware by Philadelphia; North and South Dakota by St. Paul; Nevada by San Francisco and Los Angeles; and Wyoming by Denver. Our experience in these areas has been positive. We have been able to provide services to veterans efficiently and more cost effectively than if there was a separate office for each State. However, we will obtain a copy of the HUD data on their consolidation effort and review it in an effort to assure ourselves that we have taken measures to avoid the problems they experienced.

New England Economy

News accounts indicate that the Massachusetts and southern New England economy is experiencing a slowdown.

5a. Are the regional economic assumptions on which the consolidation was proposed still valid? What changes, if any, have been made to the original consolidation proposal to reflect the region's changed economic situation?

ANSWER: Yes, we believe the economic assumptions are still valid since the situation in New England has not changed dramatically. There has been some softening of the market, particularly in Massachusetts. However, our workload indicators do not show a great increase in loan or property management activities. We will continue to monitor the workloads in New England and make whatever adjustments in staffing are indicated. At this time, we see no valid reason to justify a change in our decision recommending Manchester as the site for the consolidated Loan Guaranty Division.

5b. The plan and justification notes that the New England program is "predominately origination-oriented". Does the consolidation proposed take into effect the changes in program activities associated with downturns in local economies, especially serving of defaulted loans, loan terminations, and property management?

ANSWER: One of the main reasons for assembling the task force was the common concern that the Loan Guaranty program in New England could be at risk because of the shifting economy and the lack of expertise to deal with back-end business. We believe that the proposed staffing can handle the program activities now being experienced. However, we will continue to monitor workloads and performance in New England to assure that staffing can provide the service that veterans and program participants have come to expect.

Togus Property Management

Fifty eight of the entire region's 76 properties are managed by the Togus office.

6. How does Central Office explain the wide differences between the four offices that would lead to Togus to having such a relatively large managed property activity?

The property management inventory in Togus and other New England stations has varied over the last few fiscal years. The trend has been that the inventory of properties in Maine has been greater than the surrounding states because the rate of foreclosures has been higher. However, relative to other areas of the country, the foreclosure rate and property inventory are quite low. At the end of February 1990, the total number of properties under VA management in New England was as follows:

Manchester	27
Togus	25
Boston	8
Hartford	1
TOTAL	61

Our data shows that most of the foreclosures are occurring in Vermont, New Hampshire and Maine. The rapidly escalating real estate markets in Massachusetts, Connecticut, and Rhode Island have held origination and foreclosure activity to a minimum in those states.

Department of
Veterans Affairs

Medical & Regional
Office Center

Togus, Maine 04330
(207) 623 - 8411,
Extension 5282

News Release

October 5, 1988

For more information call
Jim Simpson at 623-5714

The Loan Guaranty Division at the VA Medical and Regional Office Center at Togus and three other New England Loan Guaranty Divisions will be consolidated at the VA Regional Office in Manchester New Hampshire. This action is being taken to improve the efficiency and effectiveness of Loan Guaranty operations in New England.

Loan Guaranty Divisions administer the VA Guaranteed Home Loan program including loan processing, appraisal, and property management. Workloads in the divisions to be consolidated support only minimal employment levels. These small divisions have high overhead costs. A consolidated division will result in greater depth of coverage in all program areas and is expected to result in significant cost savings.

Togus staff will still be involved in providing program information and assistance. Maine veterans will receive the same high level of service in the Guaranteed Loan program that they have come to expect.

There are ten employees in the Togus Loan Guaranty Division. All employees will be offered the opportunity to work at Manchester or will be offered alternative employment at Togus.

Report of Contact
Consolidation of Loan Guaranty Division
VAMROC, Togus, ME

October 5, 1989

2 p.m.

The Director, Assistant Director, Regional Office and Personnel Officer met with employees of Loan Guaranty Division along with Walter Glockler, President, AFGE Local 2610. They provided copies of a letter on the consolidation.

3 p.m.
Steve Hart, Senator Mitchell's Washington Office

I called Steve Hart and provided information about the consolidation of Loan Guaranty Division as contained in our letter to employees. Steve expressed some concern for the possibility of diminished service to Maine Veterans. I said that we supported the consolidation and believed that the same level of service to Maine Veterans could be maintained. He asked how many employees were involved. I told him that there are ten authorized positions in Loan Guaranty Division with the Chief position now open. He thanked me for the information.

Following this call, the same information was provided to Jim Bodner of Senator Cohen's Washington Office, Jane Calderwood of Congresswoman Snowe's Washington Office, and John O'Brien of Congressman Brennan's Washington Office.

The Assistant Director, Regional Office met with the American Legion, AMVETS, Bureau of Veterans Services and Veterans of Foreign Wars Service Officers. Information in the letter to employees was provided to them. The Center Director met with Disabled American Veterans Service Officer.

A news release was sent to all Maine's media and is attached.

James R. Simpson
Public Information Officer

Attachment

Medical and Regional Office Center
Togus ME 04330

Veterans Administration

Release #89-18

October 10, 1989

In Reply Refer To: 402/00

TO: All Program Participants

SUBJ: Consolidation of All New England Loan Guaranty Activities (Boston, Hartford, Togus, and Manchester) at Manchester, NH VA Regional Office

1. Loan Guaranty workload levels at VA's New England offices have become too low in recent years to justify services at four seperate locations. After extensive study to determine how VA could continue to provide the best service to New England veterans and program participants, it was concluded that there should be a consolidation of Loan Guaranty operations at the Boston, Hartford, Togus and Manchester VA offices into the VA Regional Office in Manchester, New Hampshire.

2. In reviewing various alternatives to resolve problems related to inefficiencies arising from minimal personnel resources at the affected offices, the VA's commitment to provide quality service in a timely manner was always a priority consideration. As the consolidation proceeds, you may be certain that every effort will be made to avoid disruptions to the effective service you should expect in your dealings with this agency.

3. We recognize the importance of giving participants advance notice of the various stages of the consolidation and the changes they will entail. You will be notified of the effective date for the consolidation in a forthcoming release from the Manchester VA Regional Office. Instructions will be provided as to when and where to direct mail and calls regarding appraisals, eligibility requests, loan applications, guaranties, specially-adapted housing, servicing of delinquent GI loans, payment of claims, VA-acquired properties, and other related matters at the consolidated Manchester Loan Guaranty activity. Walk-in service for certificates of eligibility will continue to be offered through the Veterans Services Division at the Boston, Hartford, and Togus VA offices.

4. Once the operations are transferred, you will be furnished a listing of the New Hampshire office's key Loan Guaranty personnel and their phone numbers.

5. Your cooperation is essential to the success of the consolidation, and we hope we can count on your patience and understanding while any minor organizational problems that occur are identified and worked out. We believe, however, that once the consolidation is completed, you will find that we will be better able to serve your needs and to provide consistently timely service to veterans and Loan Guaranty program participants.

Sincerely,

THOMAS A. HOLTHAUS
Center Director

"America is #1—Thanks to our Veterans"

NEW ENGLAND ORGANIZATIONAL PLAN

LOAN GUARANTY DIVISION

OFFICE OF THE CHIEF (3 FTE)

Loan Guaranty Officer (GM-14)
Assistant Loan Guaranty Officer (GS-13)
Division Secretary (GS-5)

CONSTRUCTION AND VALUATION/LOAN PROCESSING (12 FTE)

Section Chief (GS-12)
SAH/Condo Specialist (GS-11)
Construction Analyst (GS-11)
Appraisers (GS-11) - 3
Loan Specialists (GS-9) - 3
Program Clerks (GS-5) - 2
Clerk Typist (GS-4)

LOAN SERVICE AND CLAIMS/PROPERTY MANAGEMENT (10 FTE)

Chief (GS-12)
Realty Specialist (GS-11) - 2
Realty Specialists (GS-9) - 1
Loan Specialist (GS-11) - 1
Loan Specialists (GS-9) - 2
Program Clerks (GS-5) - 2
Clerk Typist (GS-4)

Responses to Questions by Senator Rockefeller of
West Virginia During Testimony Before the
Committee on Veterans' Affairs
United States Senate
February 23, 1990

Following are responses to the questions raised by Senator Rockefeller regarding the Local Veterans' Employment Representative (LVER) Program in West Virginia, and its relationship to our national programs. As Senator Rockefeller indicated, unemployment is high in parts of West Virginia with rates ranging from approximately 19.5% down to as low as 2.5% in the Eastern panhandle for an average unemployment rate of nearly ten percent. The allocation formula provides 18 LVER positions to cover the entire State of West Virginia. We are pleased to report that all LVER positions are filled at this time. Given the high turnover rate last year, caused by early retirement incentives, there are several newly appointed LVERs. We look forward to sending them to the National Veterans' Training Institute this year to further enhance their skills to provide direct services to veterans. Thus, they will provide more meaningful functional supervision to all other Job Service staff to improve the levels of service provided to the veterans residing in West Virginia.

Given these facts, we are pleased to report that LVER staff in West Virginia placed 916 of the 3,130 veterans placed by the West Virginia Job Service last Program Year, which ended June 30, 1989. This represents 29.27% of all veterans placed in West Virginia that year. Senator Rockefeller will be pleased to learn that this relates quite favorably to the National average. Of the 563,068 veterans placed in Program Year 1988, LVER staff placed 119,600 or 21.24% of the total veterans placed, nationally. Regarding the accomplishments by LVER staff nationwide, of the 2,335,888 veterans who applied for service with the Job Service, 447,606 or 19.16% were first served by an LVER. We are pleased to find that 26.72% of that number of veterans or 119,600 were placed by LVER staff.

Nationally, our Disabled Veterans' Outreach Program (DVOP) specialists have also assumed a greater percentage of the overall services provided to veterans by the Job Service. In the last Program Year, DVOP staff placed 140,761 of the 563,068 veterans placed by Job Service. The percentage of all veterans placed that were placed by DVOP staff was 25%. DVOP specialists took applications for 606,227 veterans. The number they placed (140,761) is 23.22% of the number of veterans' applications taken.

The total Job Service reflected a placement rate of 21% for all applicants and 24.1% for the 563,068 veterans placed last Program Year. Since our DVOP specialists and LVER staff accounted for 46% of those veterans placed, you can see why we are proud of their efforts on behalf of our nation's veterans.

○